

103
THE BLUE CROSS/BLUE SHIELD OF THE NATIONAL
CAPITAL AREA SELECT PREFERRED PROVIDER
PLAN

Y 4. P 84/10:103-49

The Blue Cross/Blue Shield of the N... **ARING**
BEFORE THE
SUBCOMMITTEE ON
COMPENSATION AND EMPLOYEE BENEFITS
OF THE
COMMITTEE ON
POST OFFICE AND CIVIL SERVICE
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
SECOND SESSION

JULY 19, 1994

Serial No. 103-49

Printed for the use of the Committee on Post Office and Civil Service



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(III)

THE BLUE CROSS/BLUE SHIELD OF THE NATIONAL CAPITAL AREA SELECT PREFERRED PROVIDER PLAN

TUESDAY, JULY 19, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS,
Washington, DC.

The subcommittee met, pursuant to call, at 11 a.m., in room 311, Cannon House Office Building, Hon. Eleanor Holmes Norton (chair of the subcommittee) presiding.

Members present: Representatives Norton, Byrne, and Morella.

Ms. NORTON. Good morning and welcome.

Today we hold a hearing on an issue that is central to health care reform. Managed care has become a controversial and increasingly widespread methodology in health care delivery. Some hail it as the answer to cost containment. Others say it hurts patient care.

The issue before this subcommittee today is illustrative of this conflict. Blue Cross/Blue Shield is the most popular health plan in the Federal Employee Health Benefits Program, with almost 50 percent of the FEHBP enrollees nationwide selecting Blue Cross/Blue Shield as their health plan. Thus, providers wishing to offer services through Blue Cross/Blue Shield are justifiably concerned about their ability to continue to participate in the program.

In January 1993, Blue Cross/Blue Shield of the National Capital Area began its select preferred provider plan. Prior to 1993, Blue Cross/Blue Shield offered a Preferred Provider network that included over 6,000 providers. At the time the SPPP replaced the former network, it included approximately 5,000 providers. Currently, the SPPP includes approximately 6,200 providers and is the network available to Federal enrollees in Blue Cross/Blue Shield in the Washington metropolitan area. However, according to the Medical Society of the District of Columbia, many providers in the District who were in the earlier network are still excluded from participation.

The Medical Society also complains that providers are not informed about the manner in which selection occurs. This hearing will examine the effect of the SPPP on Federal enrollees, as well as on health care providers.

Our concern, of course, is for this immediate situation. In addition, however, we believe the issue of how providers are included or excluded from existing networks is one of the central issues of health reform itself and that the Blue Cross/Blue Shield experience

can be useful in evaluating the health care bills now before the Congress.

I welcome today's witnesses and say that I look forward to hearing their testimony.

Mrs. Morella has arrived, our ranking member. I will ask her to begin by making any opening statement she may have.

Mrs. MORELLA. Madam Chair, it is a pleasure to join you this morning on an issue which may affect the health care issue in a very significant manner. I want to congratulate you for acting expeditiously to air out differences in an open forum and for the effort by both parties in a recently filed suit to testify.

I hope that solutions will emerge from this hearing, even if they have to be, as we say on the Hill, creative. As we well know, this subcommittee, under your guidance, has been able to formulate substantial creative solutions.

What I will do, in the interest of time, Madam Chair, is ask the record to include my opening statement in its entirety. And I yield back any time I may have had for the opening.

Ms. NORTON. Thank you very much, Mrs. Morella.

[The prepared statement of Hon. Constance A. Morella follows:]

PREPARED STATEMENT OF HON. CONSTANCE A. MORELLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Madam Chair, it is a pleasure for me to join you this morning on an issue which may affect the health care issue in a significant manner. I congratulate you for acting expeditiously to air out differences in an open forum and for the effort by both parties in a recently-filed suit to testify.

I certainly hope that solutions will emerge from this hearing, even if they have to be, as we say on the Hill, creative. But, as we well know, this subcommittee, under your guidance, Madam Chair, has been able to formulate substantial creative solutions.

There is no doubt in my mind that we must be vigilant and try to contain health care costs. Insurers and providers have a joint stake in this matter and must work together to ensure quality, affordable health care for all.

Going through the testimony, Madam Chair, made me feel a bit queasy, somewhat seasick, rocking from port side to starboard. Each witness makes valid points and raises genuine concerns but they are simply diametrically opposed. Sometimes it appears that if there were true open dialogue, some of the problems could have been avoided.

For instance, if Blue Cross/Blue Shield could let providers know why there were not selected or why there were deselected, physicians could either remedy the situation or decide that they would rather not participate in the program because conforming to the program elements may not be worth their efforts. However, it would be the provider's choice; they would not be left with unanswered questions.

I will also be interested in knowing why doctors practicing both in the District and in the suburbs were chosen only in their suburban practice. I am also very concerned about the allegation that providers were not chosen because of the type of practice they are involved in, particularly in the District of Columbia. I note that Blue Cross/Blue Shield abhors any form of discrimination. However, we are not talking about employment discrimination. We are talking about physical conditions of Federal employees and retirees and their families. They must not have disparate treatment because of where they live or what type of illness they may have. We cannot have this form of red-lining in our FEHB Program. I hope that we will receive enough evidence to prove that this is not the case.

Additionally, I would like to caution providers that if they fail to contain costs, or if they contain costs and in turn require more office visits, or if they use unnecessary tests—either as a protection against malpractice or because they are unsure of their own capabilities in diagnosing illness, there may have to be additional monitoring (even computer monitoring) so that fair, adequate and cost-effective treatment is rendered to all patients.

As one of the witnesses mentions in testimony, the FEHBP is touted as a model for health care reform. Even in trying to retain it at its high standard, there is no

doubt that OPM and this subcommittee must make positive changes in order to contain cost yet give the Federal sector choices which are meaningful. Indeed, the choice given by the BCBSNCA is: You can go to your own provider and if she (or he) is not on the preferred provider list, you must bear more of the cost; if you go to someone on the preferred provider list, your out-of-pocket will be less and, thirdly, if you go to someone on the selected preferred provider program, your out-of-pocket cost will be even less or negligible because they have accepted some qualifying guidelines of the insurer. It is an individual's choice, but it may be expensive to some long-term doctor-patient relationships.

Madam Chair, I will as always be ready to work with you to bring about an amicable resolution to the problem before us.

Ms. NORTON. I will ask Ms. Byrne if she has any opening statement.

Mrs. BYRNE. Thank you, Madam Chair, I don't have a formal opening statement. I will just share with the committee that we just received 14,000 returns on our health care questionnaire, and the No. 1 concern was able to choose your doctor; and so I am very interested in what is happening in the committee today, and also what is going to happen in health care reform vis-a-vis these issues.

Thank you, Madam Chair.

Ms. NORTON. Thank you very much, Ms. Byrne.

I would like to hear from our first witness, Mr. Curt Smith, Associate Director for Retirement and Insurance at the Office of Personnel Management.

Mrs. MORELLA. May I, first, Madam Chair, ask you to yield for a moment.

Ms. NORTON. Of course.

Mrs. MORELLA. I wanted to mention, I learned earlier today that Dr. Morris has been named to head the Federal Executive Institute in Charlottesville. I wanted to congratulate him on that.

Thank you.

Ms. NORTON. You may proceed.

STATEMENT OF CURTIS J. SMITH, ASSOCIATE DIRECTOR FOR THE RETIREMENT AND INSURANCE GROUP, OFFICE OF PERSONNEL MANAGEMENT

Mr. SMITH. Thank you. It is a pleasure to be here, I appreciate the opportunity to testify about what are, to us, very important issues. If it is all right with the Chair, I will submit my testimony for the record and just very briefly summarize what seem to be the critical issues here.

The recent publicity about FEHBP has tended to be wildly favorable. While we at OPM who run the program are flattered, we are not fooled; we understand these are complicated issues and we have much to learn and perfect in our program. But we think the program is fundamentally good and that it is doing some things successfully.

We have enjoyed relatively mild premium increases in recent years, and we attribute that in large part to the creation and much broader use of provider networks in our fee-for-service plans. For example, in a report we submitted to the Congress last fall, we are estimating that the combination of preferred provider organizations being used in FEHBP are saving \$700 million a year. That is a significant amount of money.

We have been encouraging our plans, and I will give them credit for having begun the networks, but we have sought to encourage them to perfect and extend their networks. The approach that we have encouraged has been that traditional benefits remain as they are and that networks are not introduced at the expense of what participants had been getting but instead are an add-on to the traditional benefit, so the network serves as an inducement for people to come in rather than a punishment for people who stay out of it.

That is the case in the Blue Cross/Blue Shield network. If you choose a doctor outside the network and preserve your complete choice of the physicians you would like to see, you continue to get the traditional Blue Cross benefit. If you are willing to forgo some of your choice and restrict the doctors whom you can select, you may in turn receive a better benefit, and that choice is yours.

We think this is a good combination for the FEHBP enrollees and that is the group we represent and most care about. They have complete freedom to choose doctors, they have improved benefit if they wish to restrict choice of doctors to those in the preferred provider network, and they have, as a result of this nationwide phenomenon, significantly lower premiums. For those reasons, we have encouraged the evolution of networks in FEHBP.

I will close my introductory remarks with that and be happy to answer questions.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF CURTIS J. SMITH, ASSOCIATE DIRECTOR FOR THE
RETIREMENT AND INSURANCE GROUP, OFFICE OF PERSONNEL MANAGEMENT

Madam Chair and members of the subcommittee: I am pleased to be here today to discuss OPM's interest in offering good quality health care services at the lowest cost to Federal employees and retirees through such programs as the select preferred provider plan, a network of hospitals and physicians formed by Blue Cross and Blue Shield of the National Capital Area. Washington Area participants in the Federal Employees Health Benefits Program [FEHBP] who are enrolled under the Blue Cross and Blue Shield governmentwide service benefit plan have been offered the option of receiving covered services through the Blues select preferred provider plan since January 1993.

Local Blues plans in specific areas began to introduce the preferred provider concept to Federal service benefit plan subscribers in 1986. The concept has been expanded successfully until all local plans had preferred provider networks in place by 1993.

Over the past few years, the other fee-for-service plans in the FEHBP also have been working to develop and expand preferred provider networks. Currently 10 of the 14 traditional fee-for-service plans in the program, including all seven that are open to all eligible enrollees, have preferred provider programs for both hospital and physician services. As a result, almost all FEHB fee-for-service plan enrollees have access to this option.

Under preferred provider arrangements, a health plan carrier identifies physicians, hospitals, and other providers of medical services who satisfy the carrier's criteria for providing good medical care and who will agree to provide covered services for the carrier's enrollees at discounted charges. Then, the carrier offers its enrollees enhanced benefits when they obtain covered services from preferred providers.

Under the Blue Cross and Blue Shield structure, local plans retain responsibility for selecting a network of preferred hospitals and physicians and negotiating discounted charges, just as the local Blues plans are individually responsible for traditional agreements with participating providers and member hospitals. Before 1993, each local plan also determined the structure of enhanced benefits available to each FEHB enrollee to encourage use of preferred providers.

For the 1993 FEHB contract year, Blue Cross and Blue Shield proposed incorporating preferred provider benefits into its governmentwide service benefit plan contract and bringing such benefits more in line with mainstream managed care philosophy. The plan incorporated network benefits for enrollees in all areas, offered

significantly reduced payment liability for enrollees using network providers, placed strong emphasis on establishing cost-effective provider networks, and added a free-standing preferred retail drug benefit and corresponding network for the Federal employee program to encourage use of cost-effective providers across a broad array of covered services. The select preferred provider network offered by the National Capital Area plan is the component for this area of the national program.

As in the past, if an enrollee chooses to use a non-preferred provider, benefit payments are made at traditional service benefit plan levels depending upon provider status, that is, whether a physician is participating or non-participating and whether a hospital is a member hospital or not. OPM agreed that this proposal would achieve a desirable balance between continuing to provide a comprehensive benefit package for FEHB enrollees and meeting necessary cost-containment objectives.

Although OPM encourages carriers to make preferred provider benefits accessible to all enrollees to the greatest extent possible, OPM assumes no involvement with the process of selecting which providers are considered preferred by the plans. OPM neither contracts with individual health care providers nor participates in negotiations of preferred provider arrangements. Any agreements made between carriers and health care providers choosing to participate in such arrangements are private transactions between the two parties.

As administrator of the FEHB program, OPM's basic responsibility is to make affordable health benefits coverage available to Federal employees and retirees and their family members. At a time when other employers are experiencing significant increases in costs to provide health benefits to their employees, we are pleased to have been able over the last several years to keep the costs to FEHB enrollees down while continuing to maintain the comprehensive health insurance protection enrollees have long relied upon receiving. This is largely the result of blending cost containment and managed care into the benefit packages offered. OPM encourages and takes advantages of any preferred provider arrangements, negotiated discounts, mail order prescription drug programs, and similar arrangements our carriers may offer which appear cost-effective and which enhance benefits available to our enrollees. Such arrangements generally supplement, and do not replace, the carrier's existing benefits. While traditional fee-for-service benefits for covered services continue to be available, enrollees benefit from lower costs because of their use of managed care arrangements. It is our hope that enrollees will take advantage of these features when available, since this will result in savings or broader benefits to enrollees and savings for the program as a whole. However, the choice remains with the individual.

We appreciate and welcome your subcommittee's interest in the Federal Employees Health Benefits Program and look forward to continuing to work together to restrain costs and preserve sound benefits for our enrollees. I would be glad to answer any questions you may have at this time.

Ms. NORTON. Thank you, Mr. Smith.

When did OPM first learn of the decision of Blue Cross/Blue Shield to implement this new SPPP?

Mr. SMITH. My memory is not precise, but the new network, which is what I think you are talking about, began in January 1993. We would have paid attention to it probably in the summer of 1992 preceding that contract year.

Ms. NORTON. Did you receive any information about the methodology they were going to use for selection?

Mr. SMITH. Yes, ma'am, we did. We were briefed in part by the doctor who will testify on behalf of the Blue Cross/Blue Shield National Capital Area plan later about the criteria and how the computer Pro/File works.

Ms. NORTON. What was that information?

Mr. SMITH. I am not going to be able to recall the details, but it seemed to us to be a very sophisticated approach to making these decisions. There was an extraordinary quantity of data available that was processed in order to help the Plan make the judgments about which physicians were practicing in ways that were helpful and cost-effective.

We were reassured that they had controlled for some of the obvious things you worry about in these decisions, and that is, for example, physicians or practices of physicians who treat sicker-than-usual patients or older-than-usual patients. The Pro/File system accounts for that so you get to what you really want to know.

Ms. NORTON. So essentially you were briefed. You don't see that you have any role except to receive information on such changes?

Mr. SMITH. Well, let me enlarge that just a little bit because this is only 1 of 65 Blue Cross operations that all together comprise the national Blue Cross plan that is in FEHBP.

I will tell the Chair, I have had briefings on several local networks, but by no means all of them, which leads to the point, I think, that in the arrangement that is FEHB, we contract and pay Blue Cross for developing packages and so on. Our fundamental concern is for the well-being of enrollees, which we judge to include several things, including as low a premium as we can get for them, as well as making sure that nothing untowards is going on.

So if we were to see a pattern of enrollee problems, our attitude would become much more aggressive than it has needed to be on this issue.

Ms. NORTON. You don't see any pattern of enrollee problems with the decertification, as it were, with hundreds of physicians?

Mr. SMITH. No, ma'am.

We have had some phone calls. It is a big program, and we always have phone calls. We have not had a significant number of complaints about this network.

Ms. NORTON. When did you first learn of the Medical Society's concern about the selection process?

Mr. SMITH. I had heard rumblings over the past year, although the Medical Society itself has not brought any concerns directly to my attention.

Ms. NORTON. It is interesting, because they certainly brought it to my attention.

Mr. SMITH. Yes.

Ms. NORTON. If the society were to bring these concerns to your attention, what would your obligation, if any, be? You will hear some of this testimony that there were hundreds of people who used to be in Blue Cross/Blue Shield, and you are talking about enrollee concerns?

Mr. SMITH. Yes.

Ms. NORTON. Put yourself in the position of an enrollee who learns that a doctor is no longer in the network and try to multiply that many times, because our concern is first for the patients, for enrollees, potential patients or enrollees that may have been affected. It is amazing that you have not heard.

By the way, given the number of physicians involved that are no longer enrolled, let me put a hypothetical since you did not learn of it. Suppose there were hundreds of physicians that were not in the plan anymore. What would be your obligation, if any?

Mr. SMITH. The only obligation I would feel would be to act on behalf of enrollees. We share that common concern, I think.

And let me talk about what I think this must look like to an enrollee and what I see as the worst-case decision an enrollee would have to make.

Assume that one had been seeing a physician that was in the looser, earlier network; if that physician was not in the network beginning in 1993, as a patient, as an enrollee, my decision is now, is it worth it to me to see this doctor and to receive a 75-percent reimbursement against a reasonable charge, or do I want to select another doctor where I can go for \$10 or have 95 percent of the surgeon paid.

That is kind of a cost/benefit decision that each of our——

Ms. NORTON. I am quite aware of how the individual enrollee would proceed. I am trying to find out if you have any role, monitoring; or whatever the provider network does, you just assume is appropriate?

Mr. SMITH. Having looked at what was being done to set the network up and having been comfortable that it was a worthwhile thing to do, I think that our role then became, if we saw problems, we would need to deal with them. What I am saying is that we have not, from the enrollee perspective, seen any degree of problems around this network.

Ms. NORTON. There is a change?

Mr. SMITH. Yes.

Ms. NORTON. What is the major benefit of the change you perceived?

Mr. SMITH. Two things, it has saved us premium dollars——

Ms. NORTON. How many?

Mr. SMITH. Nationwide, \$300 million. That is a very rough number; I will be more precise for the record if you like.

Ms. NORTON. I would appreciate that. It is very important.

[The information referred to follows:]

We estimate that in 1993 Blue Cross hospital networks saved the FEHBP \$215 million and physician networks saved \$110 million for a total savings of \$325. The prescription drug PPO is estimated to save an additional \$125 million. A significant portion of these savings were used to pay for a higher level of benefits to people who use the networks.

Mr. SMITH. I will extrapolate for illustration, about 10 or 11 percent of our Blue Cross enrollees are in the District. If that is 10 percent of the savings, which is reasonable, we are talking \$30 million a year in this particular area in premium savings.

Not only that, the old network paid for the bills of the patients at 80 percent of the charges instead of the usual 75 percent of the charge. Or it may have been 85; the networks varied some in the earlier manifestations. That jumped to 95 percent of surgeons, charges and all but \$10 per office visit. So our enrollees immediately saw a better benefit every time they saw a physician, as well as lower premiums. That is why it is attractive to us.

Ms. NORTON. I want to understand how this works, however, because as I understand it, the Blue Cross plans and FEHBP are nationally rated as opposed to community rated.

Mr. SMITH. Right.

Ms. NORTON. If that is so, I don't understand how enrollees in this area are saving money with the SPPP when premiums are the same everywhere in the country.

Mr. SMITH. That is an interesting phenomenon because everybody in the FEHB Blue Cross plan has a lower premium because

of the use of networks, whether or not they use the networks personally or not. So you can't draw a one-to-one connection.

But a reasonable approximation of the premium savings from the District of Columbia, as I suggested earlier, is about \$30 million. That is how much less Blue Cross is having to pay in claims because of the use of the network. So that while it is true that it is a nationwide network, what is happening in each of our cities contributes to that bottom-line cost just as each of us contributes to the premium. It does come back to everyone.

Ms. NORTON. This is an important feature, obviously, given the costs of health care.

Given the savings that you say are realized nationwide, if these savings are nationwide and you are so pleased with them, then why are you not encouraging other plans to do the same thing that has been done here? I can't understand how you would have \$30 million being saved and not virtually requiring your similar plans to go around saving you \$30 million and bring down all of our costs in premiums?

Mr. SMITH. We have actually done that. We have not taken the step of requiring networks, although it has not been necessary. All of our fee-for-service plans, open nationwide, have networks. They are not all as good or extensive, but everybody is doing networks because it has evolved as a critical way of controlling premiums; and FEHBP enrollees are very sensitive to premiums. If you want to keep them, you have to keep the premiums competitive, and the way that's done most recently is through networks.

It is also important—and you mentioned the kinds of issues in national health reform that we also see in these contexts—that FEHB gives enrollees an extraordinary amount of choice. I think that choice is a real value. You start off with a choice between HMO and fee-for-service plans, and the HMO's are restrictive.

In the fee-for-service, you have an in- or out-of-network choice. We have a system that is, so far, preserving the ability of our enrollees to go to any physician they choose, if they wish to make the decisions at each of the junctions that—

Ms. NORTON. Let me ask you about choice regarding your own options. Could you, OPM, choose to offer the Blue Cross PPP and not limit the network of providers to the SPPP?

Mr. SMITH. That is a hard question for me to answer because I will have to talk a little about the structure of FEHB.

Our contract is with the National Blue Cross/Blue Shield Association—which operates a Federal Employee Program Office to deal with OPM. They are the ones who work with each of the local plans and deal with the locals on which network, if there are two or three products available, they wish to use.

Certainly, our voice would be an important one. We don't contract directly with the National Capital Area BC/BS plan, however, so I need to be a little cautious about that.

I should say in honesty that we are pleased with the National Capital Area network. I don't want to hedge on that. I don't have a problem with it.

Ms. NORTON. How would you characterize your monitoring role, if any, for these plans?

Mr. SMITH. In that particular area?

Ms. NORTON. Generally.

Mr. SMITH. Our inspector general audits plans; that is, auditors look at who got charged what and if the bills were proper. Then we ourselves are spending more and more time, as we are able to, visiting plans and trying to understand in more detail the kinds of things going on. But I think still our fundamental monitoring device is the reaction of the people we serve. When we begin to see recurrent problems and repetitive problems, we become more and more engaged in trying to address those.

Ms. NORTON. Mrs. Morella.

Mrs. MORELLA. What I wanted to say is what is in a name; and when you have got a name like Smith, it can be confused with others, so—

Mr. SMITH. I could do better with a name like Morris.

Mrs. MORELLA. I want to apologize for giving you another name, Mr. Smith. Actually I have been scanning the Blue Cross/Blue Shield and the Medical Society of the District of Columbia testimony that we have before us; and we are going to, subsequent to the testimony you have given us in response to questions, be hearing from them.

I hope that you will look at the Medical Society of the District of Columbia concerns within the testimony, review it and maybe get back to us in terms of your reaction to it.

Again, picking up on what the Chair has said, how do you formally monitor these situations? Do you then wait for enrollees to complain? And maybe they are not complaining, as you have stated. Do you rely on the inspector general? Could you reiterate how you monitor those conditions?

Mr. SMITH. The answer is, all of the above. We use whatever sources we can use to maintain a sense of what is going on with particular plans and what is working and where the problems are.

On this particular local network, we first learned how it was being put together and we were pleased with what we heard, and given that we watch for feedback from our enrollees, from the Congress, wherever it comes from, we are willing to take it and do what we need to do to reassure ourselves that things are as we want them to be.

Mrs. MORELLA. And you have no suspicion that there were any concerns or problems or difficulties?

Mr. SMITH. The concerns and problems that I am aware of are those expressed today by the doctors in the D.C. Medical Society. Their concerns are the ones that I know about, but that is all.

Mrs. MORELLA. What do you do with Federal carriers to assess the appropriateness of their networks in terms of location, specialties, and the number of doctors?

Mr. SMITH. That is a very good question because we do it in two very different ways.

When we are looking at HMO's, for example, we are very careful to see that they are going to provide people all their medical care needs, that they are staffed to do that and have the right expertise in sufficient numbers to meet whatever needs our enrollees bring to them.

It is much less critical in the networks we are talking about with Blue Cross because that network, in fact, is an enhancement. And

so we want the enhancement wherever we can have it to whatever degree we can get it. We don't have to wait for it to be complete before we can benefit from it, because the fundamental, underlying fact is that people continue to have all their usual traditional rights to go to whomever they want to go to and receive their expected reimbursement rates.

Mrs. MORELLA. Do you get involved with due process, within the organization?

Mr. SMITH. Only where our enrollees think claims have not been properly paid, they might come to us with a due process appeal.

Mrs. MORELLA. So you rely heavily on what you hear from enrollees?

Mr. SMITH. Very heavily, yes.

Mrs. MORELLA. Thank you, Madam Chair.

Ms. NORTON. Thank you, Mrs. Morella.

Mrs. BYRNE.

Mrs. BYRNE. Mr. Smith, as you gave your testimony and you talked about premium savings that accrue to this system, can you tell us, is there any way to figure out what the cost is—that is, because the enrollees pick up more of the cost to keep their own doctor? If the enrollees are now paying 75 percent—excuse me, 25 percent, that would obviously lower the premium costs because of paying the higher deductible. So whether it is a better standard of practicing medicine or you have more enrollees picking up more deductible, these would both lower the premiums, correct?

Mr. SMITH. No, the baseline against which we measure the saving is the baseline that says what we have always done is to pay 75 percent of the usual charges. So we are looking to see what the costs would have been had we continued that arrangement versus the cost if the people used the preferred provider network. In that sense, there are not savings from people who choose not to go. We are not charging more money for people out of network. We have held them where they have always been and saved some money and offered inducements to those who come into the network.

Mrs. BYRNE. The inducement then is really that you are going to pay 95 percent to belong to this network?

Mr. SMITH. Yes.

Mrs. BYRNE. And that if you stay in the old network or the fee-for-service plan, you are going to pay the customary 75 percent for the enrollee?

Mr. SMITH. Right.

Mrs. BYRNE. OK. How does that figure into your savings of \$30 million we are supposing the system saves in the Washington metropolitan area? Do you have any figures on how many people, or did Blue Cross present you with figures on how many people, would stay at the old 75-percent rate as opposed to the new 95 percent?

Mr. SMITH. I can't remember the details, but I can probably get them. But making the estimates and deciding if it was a good financial arrangement required us to assume things, that people would come into the networks.

Mrs. BYRNE. Could you get the committee those assumptions that it was based on?

Mr. SMITH. I would be happy to.

Mrs. BYRNE. Thank you.

[The information referred to follows:]

At the time the national PPO was proposed, Blue Cross estimated that 40 percent of enrollees would continue to use non-PPO providers. They also estimated that 30 percent of enrollees would use non-PPO hospitals.

Ms. NORTON. Thank you very much.

I want to call the next witnesses, Dr. Mark Whitten, chair of the board of trustees, Medical Society of the District of Columbia; Dr. Rodney Ellis, vice president, Medical Society of the District of Columbia.

STATEMENTS OF MARK E. WHITTEN, M.D., CHAIR, BOARD OF TRUSTEES, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA; AND RODNEY L. ELLIS, M.D., VICE PRESIDENT, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Dr. ELLIS. Good morning, Chairman Norton. Thank you for having us. I am Rodney Ellis; I am an internist and vice president of the Medical Society of the District of Columbia, as you stated.

Before I begin, I would like to advise the subcommittee we will be submitting a longer statement for the record.

I would like to again thank you for this opportunity to discuss a very serious issue, in our opinion. We are here today on behalf of our patients as well as ourselves. We believe in our ability to provide high-quality, cost-effective care to our patients. We do not want to lose the patients we have served for years and whose medical problems we can best address.

We want to talk about and ask questions about the Blue Cross/Blue Shield of the National Capital Area and the computer software program that purports to select doctors based on frugality or cost-effectiveness in their practice, but which we believe really does something different.

Let me give you a little background. In 1992 the Blues established the preferred provider network for Federal employees, retirees, and their dependents. As you well know, Blue Cross/Blue Shield is the largest carrier in this area and serves 450,000 Federal workers and their families in the Washington, DC area.

The Blues suddenly deselected almost 4,000 doctors previously included in the regular Blue Cross/Blue Shield indemnity program and/or Capital Care provider list used by plan subscribers in selecting their personal physician. There was a larger number of doctors available, 8,700, and from those nearly 4,000—3,700 were deselected. This was a 50-percent reduction in doctors available.

It is interesting that Blue Cross' current list of doctors who participate in SPPP is not very widely available. Patients often have to call Blue Cross to see if their physician is part of SPPP. Patients are confused. Let me say that I, at first, was excluded from SPPP personally and was later accepted. So I am not here for personal reasons; I am here today because I feel strongly about the principle involved here, which is that quality of care must take precedence over cost savings.

As physicians, we want to be part of health care reform. We want purchasers of health care, whether individual patients or employers, to focus on quality, too. This involves providing more information to the public and to providers so informed decisions can be

made. We understand cost is a factor which must be considered. We want health care to be appropriate and accessible, and that means affordable, too. We want the information that helps us to continue to improve the care that we deliver, so that it is high-quality and cost-effective care. I might add that most of us participate in managed care of some type, so we are not here to just bash managed care.

Now, the Blues' action of deselecting almost half the doctors previously available to Blue Cross/Blue Shield members disrupts doctor/patient relationships. Confidence and trust in your personal physician are critical to effective care. Longstanding relationships should not be allowed to be severed by a computer in the basement of Blue Cross/Blue Shield. This is particularly true for those who are sick and chronically ill. Ironically, disrupting the continuity of care can erode the quality and ultimately drive up the cost of care. As people delay treatment, they may become more seriously ill and more expensive to treat.

Despite the Blue Cross decision to keep this methodology in a black box and its claims to have chosen frugal doctors, we believe doctors were deselected from SPPP not because of their practice styles, but because of their patients. Let me give you some examples of what occurred when SPPP was established.

SPPP initially excluded all 42 board certified, private practice neurologists who practiced exclusively in the District. Two board certified neurologists with offices in the District and in Maryland were included in SPPP, but only for the services they provided in their suburban offices. It is hard to imagine that their practice styles were any different in one location over another—the same doctors, but two different offices.

However, in looking for an explanation of why doctors must be more frugal in one location and not another, it seems possible that it is because their District patients were sicker, required more care and were more expensive to treat. This implies SPPP was designed with cost, not quality, as the determining factor.

Our preliminary analysis of the data showed the OB/GYN's in Northeast and Southeast Washington went from 38 to 7 with SPPP; this is an 82 percent reduction. Yet in the rest of Washington, the number of OB/GYN's went from 161 to 112, only a 30 percent reduction. We are using the information that Blue Cross/Blue Shield has in its network directories.

It is hard not to wonder if the patients were not more sick and needed more care and if that is why the doctors were kicked out. This is not right. Or was it because for Blue Cross/Blue Shield these doctors were less cost effective? The loss of OB/GYNs in these areas where prenatal care is lacking and where high-risk pregnancies are prevalent and infant mortality is so high, is especially bothersome to us.

Further, doctors new to the area and young doctors have been excluded from SPPP, as well, no matter what their credentials.

Dr. Tony Felice, who is a board certified internist in two areas with a cancer specialty, joined the Washington Internal Medicine Group of Washington. He had been with the group 2 months when the six-person group was dropped. Although they claimed the prac-

tice patterns of all the doctors in the group were pro/iled, that was not true of Dr. Felice. He had only been there two months.

Conversely, a large number of academic and group practice doctors were waived into SPPP without being pro/iled at all. The situation with Dr. Felice brings up another flaw in the pro/file system. We know for a fact that physicians were improperly classified, so the manner in which they were evaluated was inappropriate—like comparing apples and oranges. Dr. Felice was classified only as an internist, but because he has a cancer subspecialty, he looked to the computer like an expensive general internist physician. It is not that his practice style was inappropriate; it is that he treats cancer patients who, on average, require a more intensive level of care than someone who sees a general internist.

What we have to tell you about are real-life stories—about patients and doctors. For 2 years, we have tried unsuccessfully to learn more from Blue Cross. I wish I had more numbers for you, but Blue Cross has all the data on how many patients have been affected and the location and type of doctors deselected.

So, we have examples and we are working through other channels to try to obtain data. But this is one of the reasons we are glad that you are having this hearing, to shine light on the specific problem with Blue Cross/Blue Shield and the general problem for how “black box” procedures are used to select doctors.

Dr. WHITTEN. Thank you, Dr. Ellis.

[The prepared statement of Dr. Ellis follows:]

PREPARED STATEMENT OF RODNEY L. ELLIS, M.D., VICE PRESIDENT, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Good morning Chairwoman Norton and members of the subcommittee. My name is Rodney Ellis. I'm an internist and vice president of the Medical Society of the District of Columbia.

I would like to thank the subcommittee for this opportunity to discuss a very serious issue. We are here today on behalf of our patients as well as ourselves. We believe in our ability to provide high quality, cost effective care to our patients. We do not want to lose the patients we have served for years and whose medical problems we can best address. We want to talk about and ask questions about Blue Cross Blue Shield of the National Capital Area and its use of a computer software program that purports to select doctors based on the “frugality” of their practice, but which we believe really does quite different things.

Let me give you a little background. In 1992, BCBSNCA established a preferred provider network for federal employees, retirees and their dependents. As you well know BCBS is the largest carrier in this area and serves 450,000 federal workers and their families in the Washington area.

BCBSNCA suddenly “deselected” almost 4,000 doctors who were previously included in the regular BCBS indemnity program and/or Capital Care provider list used by plan subscribers in selecting their personal physician—this was a 50 percent reduction in doctors available. It is interesting that BCBSNCA's current list of doctors who participate in Select Preferred Provider Plan (SPPP) is not widely available. Rather, patients must call BCBS to find out whether their physician is part of the SPPP. Patients are confused. Let me say that I at first was excluded from SPPP and was later accepted. I'm here today because I feel strongly about the principal involved here: quality of care must take precedent over cost savings.

As physicians, we want to be part of health care reform. We want purchasers of health care—whether individual patients or employers—to focus on quality. This involves providing more information to the public and to providers so that informed decisions can be made. We understand cost is a factor which must be considered. We want health care to be appropriate and accessible; that means affordable too. And, we want information that helps us to continually improve the care that we deliver so that it is high quality and cost effective care. I might add that most of us participate in managed care of some type—so we are not here to bash managed care.

The BCBSNCA action of deselecting almost half the doctors previously available to BCBS members disrupts doctor-patient relationships. Confidence and trust in your personal physician are critical to effective care. Long standing relationships should not be allowed to be severed by a computer in the basement of BCBS. This is particularly true for those who are sick or chronically ill. Ironically, disrupting the continuity of care can erode the quality and ultimately drive up the cost of care. As people delay treatment, they may become more seriously ill and more expensive to treat.

Despite the Blue Cross decision to keep its methodology in a black box and its claims to have chosen "frugal" doctors, we believe doctors were deselected from SPPP not because of their practice styles, but because of their patients. Let me give you several examples of what occurred when SPPP was established—SPPP excluded all 42 board certified, private practice neurologists who practice exclusively in the District. Two board certified neurologists with offices in the District were included in SPPP, but only for services provided in their suburban offices. It is hard to imagine that their practice styles are any different in one location over another. However, in looking for an explanation of why doctors might be judged more frugal in one location and not another, it seems possible that it is because their District patients were sicker, required more care and are more expensive to treat. This implies that SPPP was designed with cost, not quality, as the determining factor.

Our preliminary analysis of the data shows that the number of OB/GYNs in Northeast and Southeast Washington went from 38 to 7. This is an 82 percent reduction. Yet in the rest of Washington, the number of OB/GYNs went from 161 to 112, or only a 30 percent reduction. It's hard not to wonder if the patients in these areas are not more sick and need more care and if that is why their doctors were kicked out. Or was it because, according to Blue Cross Blue Shield, these doctors were less "cost effective?" This loss of OBGYNs, in these areas where prenatal care is so lacking and where high risk pregnancies are so prevalent, and where infant mortality is so high, is especially bothersome.

Further, doctors new to the area and young doctors have been excluded from SPPP as well, no matter what their credentials. Let me give you an example: Dr. Tony Felice, who is board certified in two areas with a cancer sub-specialty, joined the Washington Internal Medicine Group. He had only been with the group for two months when the six-person group was dropped. Although they claimed the practice patterns of all the doctors in the group were profiled, this wasn't true of Dr. Felice—he had only been with the group for two months. Conversely, a large number of academic and group practice doctors were waived into SPPP without being profiled at all.

The situation with Dr. Felice brings up another flaw in the Pro/file system. We know for a fact that physicians were improperly classified, so the manner in which they were evaluated was inappropriate—like comparing apples and oranges. Dr. Felice was classified only as an internist, but because his sub-specialty is oncology, he looked like an expensive general internist physician. It's not that his practice style is inappropriate, it's that he treats cancer patients who on average require a more intensive level of care than someone who sees a general internist.

What we have to tell you about are real life stories—about patients and doctors. For two years we've tried unsuccessfully to learn more from BCBSNCA. I wish I had more numbers for you, but BCBSNCA has all the data on how many patients have been affected and the location and type of doctors who were deselected. So we have examples and we're working through other channels to try to obtain data. But this is one of the reasons we're glad that you are having this hearing—to shine light on this specific problem with BCBSNCA and the general problem for our patients when "black box" procedures are used to select doctors.

Thank you.

Dr. WHITTEN. Thank you, Madam Chairman. I am Mark Whitten. I am president of the Medical Society of the District of Columbia, and I am an ophthalmologist and a participating doctor with a number of HMO's; with Blue Cross, I am a member of their HMO, but I was deselected for SPPP.

We are not here to bash managed care, as Dr. Ellis said. I would like to follow up Dr. Ellis' remarks by talking about some of the issues involved here—issues you care about because of your oversight of the Federal Employees Health Benefits Program and because of your role in shaping health care reform.

More than anything, this is about fairness, disclosure, due process, and peer review.

I think it has become clear from the entire health care debate—individuals want to maintain their doctor-patient relationship. Our patients are concerned about preserving quality of care and affordability. They also want information so they can make informed decisions. Unfortunately, this is all being ignored under the SPPP/pro/file system.

The pro/file system is a “black box.” Our patients and potential BCBS members don’t know how providers are selected. They don’t know the factors used, the weighting, or the accuracy of the data.

Advertising about this program by Blue Cross/Blue Shield of the National Capital Area has been misleading. We believe Blue Cross has implied that the physicians they have deselected did not comply with community standards, did not have sufficient years of training, experience, or certification, did not deliver care in a cost-conscious manner, and that their medical practices were wasteful.

We know that this is not the case. Let me tell you about my colleague, Dr. Byron Cooper. Dr. Cooper is a pulmonologist and a member of Capital Care and several other local HMO’s, including the GW Health Plan. He was deselected from SPPP. But let me tell you what Blue Cross/Blue Shield of the National Capital Area really thinks about Dr. Cooper. They think so highly of him that he was asked by Blue Cross’ Capital Care program to serve as an adviser on utilization review. Capital Care gave him a cash bonus several months ago for this quality, cost-effective practice. It is a mystery to me how they could simultaneously say he wasn’t good enough, wasn’t frugal enough, for SPPP.

I would like to talk about the appeals and due process if you are deselected. There is no opportunity for a full explanation of the deselection decision or the chance to correct inaccurate information. Dr. Cooper, when not selected for SPPP, called to appeal the BCBS decision, to tell them he was misclassified, and to cite his otherwise favorable treatment by Blue Cross. He made numerous phone calls—none were returned. He had no one-on-one explanation of his deselection by Blue Cross. He didn’t get to examine and correct the Blue Cross misinformation.

Many other physicians experienced this same treatment. I would like to submit for the record the letter Dr. Felice received from Blue Cross. His group practice was deselected, and here is his “detailed explanation.” It is unintelligible.

On the issue of fairness and equitable treatment, you should know that the Pro/File system was not applied to everyone who was in the network. Instead, all doctors affiliated with teaching hospitals and some large group practices were just waived in—Pro/File was never used. BCBS said this was because these groups have only one number for all physicians. Despite Blue Cross’ advertising claims for the selectiveness of SPPP, to the best of our knowledge, approximately two-thirds of the SPPP network were never subjected to Pro/File.

What we are left with is a seriously flawed program we believe Blue Cross wants to implement across the country. Practicing physicians did not participate in setting up this process, although the impact is directly upon their patients. Doctors don’t know the cri-

teria used for selection. We don't know if the data used was accurate. If deselected, doctors received no full explanation. Some who complained loudly received explanations that involved scant, unhelpful information.

So far, your colleagues in the House and Senate disagree with this type of approach used by Blue Cross/Blue Shield. Most of the bills reported by the major committees will require health plans to publicly disclose their provider selection criteria. If they drop a physician from a network, they have to follow certain basic requirements, such as timely notice, an explanation, and an opportunity to appeal with peer review. We are confident that you will find these reasonable and fair and will add your recommendations to the House leadership on these principles. After all, as you are well aware, the Federal Employees Health Benefits Program is constantly touted as the model for the rest of the country.

Health care reform is here; the marketplace is changing, even in advance of legislation. You have an important role to play, to set the ground rules. Doctors are the ones that, day in and day out, provide care to our patients; and we think we should have a role in what the delivery system should look like. We know there will be selection criteria; we ask only to be part of validating the criteria and to be treated fairly. We believe that patients want to have confidence in how their health plan selects their doctors. We hope, as legislators and as patients, you will agree.

Thank you. Dr. Ellis and I would be happy to answer any questions.

[The prepared statement of Dr. Whitten follows:]

PREPARED STATEMENT OF MARK E. WHITTEN, M.D., CHAIR, BOARD OF TRUSTEES,
MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Thank you. Good morning. My name is Mark Whitten. I am Chairman of the Medical Society of the District of Columbia. I am an ophthalmologist and a participating doctor with a number of HMOs; with Blue Cross, I am also a member of their HMO, but I was deselected for SPPP. We're not here to bash manage care as Dr. Ellis stated. I'd like to follow up Dr. Ellis's remarks by talking about some of the issues involved here—issues you care about because of your oversight of the Federal Employees Health Benefits Program and because of your role in shaping health care reform.

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Ms. NORTON. Thank you very much.

Now, in the Congress we are dealing with very seriously competing claims. We must drive down the cost of health care. We must do something. And we must do so while making care available as it has always been and beyond that.

I am going to try to reconcile these negotiations here as we discuss this.

Dr. Whitten, you say in—the pages are unnumbered in your testimony—that advertising by Blue Cross/Blue Shield for the National Capital Area has been misleading.

"We believe," you say, "Blue Cross has implied that the physicians they have deselected did not comply with community standards, did not have sufficient years of training, experience or certification, did not deliver care in a cost-conscious manner and that their medical practices were wasteful."

What is the basis for that?

Dr. WHITTEN. In the advertisements that occurred, even in the Washington Post, the statement that they have cost-effective, quality physicians that they have selected by a special computer proc-

ess, which would obviously select the most cost-effective doctors for care, would definitely imply to the patients that came to me and spoke to me, why aren't you part of this plan? We don't understand. We always thought that you were a good doctor, that you were cost-effective, but yet the ads in the newspapers seem to say because you are not part of the plan, you are obviously something we didn't understand.

Ms. NORTON. Conceivable, Dr. Whitten, is the implication that you cost more than doctors someplace else, but you go on to say things that are very negatively implied, that I am not sure I understand, that physicians do not comply with community standards, sufficient years of training, experience, certification.

Dr. WHITTEN. These are all the points I believe Blue Cross brings up in their computer model as they purport to the Federal employees as to how they choose physicians, that they have chosen the best, based on those points.

Ms. NORTON. Well, we will question Blue Cross/Blue Shield concerning this, but at the moment I am not sure, without more explicit language, that they have made a negative evaluation of years of training, experience, and certification based on shopping around for what looks like doctors to give them, from their point of view—I stress, their point of view—a better deal.

As far as I am concerned, the most important point your testimonies raised is one that has implications of an extraordinary nature for health care, and that is whether this cost-effectiveness goes to other than the sheer price, if I may call it that, of the doctor, but implicates the degree of illness of patients. That would be very scary, to say the least.

You heard Mr. Smith testify that he had not heard from the Medical Society. Could you explain whether you have had an opportunity to sit down with anybody at OPM?

Dr. WHITTEN. We have not had that opportunity. We would enjoy having that opportunity to discuss their points with them. We have mainly spent the last year-and-a-half trying to discuss with Blue Cross these problems, to try to work it out, and we didn't feel at the moment the need to go to OPM, but felt it was best to deal with the source of the problem.

Ms. NORTON. Yes, and that is natural enough, actually. You went to the most obvious place.

We, however, on this committee will also hold OPM responsible if serious problems develop; and I would like you to make an appointment to see Mr. Smith. He was briefed by Blue Cross/Blue Shield. I think it important, if they are going to allow these decisions to be made, that they be equally briefed by physicians so they can make an informed decision.

Dr. WHITTEN. We will do that.

Ms. NORTON. The decisions seem to be made more in the marketplace than anywhere else.

Precisely what is the information you have received from Blue Cross/Blue Shield concerning the SPPP? First, I would like to know what you have received before implementation, and then I would like to know what information you have received after implementation.

Dr. WHITTEN. Let me ask Dr. Ellis to answer.

Dr. ELLIS. During 1991 and 1992, a few of our Medical Society members were on advisory committees at Blue Cross, and as far as I understand, they were told of this program being implemented. However, I don't think any one of them realized the program would be implemented without advance warning to doctors who were about to be, for example, dropped, without some sort of clear-cut—

Ms. NORTON. What was the advance warning? Any advance? What was the nature of the process of dropping the doctor?

Dr. ELLIS. I would say that these were advisory committees that some of our MSDC members were on and they were informed that this program was being developed.

What really hit us was, in the summer of 1992, as Mr. Smith said earlier, when a newspaper article describing this appeared in the Washington Post on the front page; it was truly then that we started to have our conversations with Blue Cross/Blue Shield. The full implications of economic credentialing did not hit us until then.

Ms. NORTON. You learned about it from the newspapers? The average physician learned about it from the newspapers?

Dr. ELLIS. Absolutely.

Ms. NORTON. Did they receive a notice of some kind?

Dr. ELLIS. To some degree, yes. I, for example, was not offered in the first cut to join the SPPP.

Ms. NORTON. How were you later selected?

Dr. ELLIS. As far as I understand—I don't want to be misleading—we have had discussions with Blue Cross/Blue Shield and they were forthcoming in wanting to talk with us. What they have not been able to do is give us a clear-cut understanding of this process.

Every 6 months, as far as I understand, they rerun their computer program, if you will, with the data they have received; and they make alterations that sometimes will deselect more doctors or select other doctors back in.

Ms. NORTON. Is that how you got reincluded?

Dr. ELLIS. As far as I understand, I was reinstated after another computer program run.

Ms. NORTON. Not because of any special appeal process?

Dr. ELLIS. I hope not. I should say, no, I didn't have any special appeals process and what I would say is, I hope it is not because I was a leader in the Medical Society. I don't think it was.

I don't really think that. I am just saying that—

Ms. NORTON. What changed?

Dr. ELLIS. I was told pretty much that more data possibly could have been obtained by them and—it may have been the increase in the weight of board certification that could have improved my chances.

Ms. NORTON. Your board certification you had before and—

Dr. ELLIS. It was there all along.

Ms. NORTON. So increase in the weight across the board for board certification?

Dr. ELLIS. As far as I understand.

Ms. NORTON. What is your specialty, Dr. Ellis?

Dr. ELLIS. I am a board certified internist.

Ms. NORTON. Where do you practice?

Dr. ELLIS. In Northwest Washington.

Ms. NORTON. What is your specialty, Dr. Whitten?

Dr. WHITTEN. Ophthalmologist.

Ms. NORTON. Where do you practice?

Dr. WHITTEN. In Northwest Washington.

Ms. NORTON. You have made a very serious charge, both of you, in your testimony, in effect saying that they look and they say it costs more—I must say, you have some figures that raise an inference at the very least. They say it costs more to treat patients in some parts of the city, and if you are going to practice there, it is going to cost you more to practice. It is actually going to cost you more to practice in Southeast, for example, in Washington?

Dr. ELLIS. Let me say this: We are using data that we have been able to glean from their directory-provider networks. What we are concerned about is, using the blunt edge of pure economic credentialing, how much money a doctor spends on his or her patients as a way of determining that doctor's quality. Without proving it in some sort of pilot program or verifiable program in which you went back and looked at the charts and verified this actually does work, then it runs the potential of, in fact, excluding those doctors who take care of the sickest patients.

I think it is very clear that the older patient populations in Northeast and Southeast, who have chronic diseases like diabetes and complications from that, such as heart attacks and strokes; they are the ones who need more and more resources used on them, and their doctors are being deselected. Unless you can prove that you are not unfairly deselecting doctors, we think it is unfair to these patients and it could reduce patient access to care.

Ms. NORTON. Again, make me understand—and I understand it is complicated, and I don't want to go through the technicalities. Make me understand what Blue Cross said to you about SPPP in its explanation of why it includes some physicians and excludes others. Give me your version of that.

Dr. ELLIS. Let me try it. That has been a large part of the problem, I think.

There has been earnestness in trying to say this is a complicated computer program. We have that understanding. The problem is, if you have not verified how this computer program is selecting and deselecting doctors with some sort of retrospective study to go back and see what occurred and whether it actually matched what they say it did, then there is a problem.

You will see later in testimony that there is a graph that Dr. Morris likes to use; and Dr. Morris and I have talked many times. I have seen his graph. There is a straight-line relationship between quality and cost to a certain degree, and then after awhile the quality goes down as the cost goes up. We can all agree with that.

However, we don't know how to use that graph. We have not seen it demonstrated and proven; we have not had clinical outcomes research to show how they are selecting or deselecting doctors.

Ms. NORTON. When you said to Blue Cross/Blue Shield, does your computer program deselect people who have sicker patients, were they able to say to you, it does or does not?

Dr. ELLIS. They were able to say it in that their claim is they have adequate data to compare patients from the same geographic regions to other patients; doctors in the same geographic regions, they claim that they are comparing apples to apples. Again, we don't have a problem with using economic profiling. That is one—again, one, of the many things that should be used to credential doctors.

What we are saying, though, is if you are using it—and have a claim that in the long run cost-effective care is better care, in the long run, you have to go back and prove that. There must be a pilot program. You can't do this up front, prospectively, without telling doctors what you are doing and having doctors unconscious. In fact, when we see one of the computer printouts of what our performance is, we can't understand it.

I have been through 5 years of medical school, 3 years of residency training, and 14 years of clinical practice. I think I am intelligent and I should be able to understand what selection criteria they are using. But we doctors can't understand this and, if we can't, we say this program is flawed and it needs to be reworked in cooperation with the physicians in practice to the point they can understand what is being done.

Ms. NORTON. Dr. Ellis and Dr. Whitten, I think it is very simple; unless Blue Cross/Blue Shield can disabuse me, it is driven by one factor, cost. I think it is a very simple program. What you put in, you get out. You put in how much the physician costs, and you get that out, unless there are physicians that you, for some reason, want to keep in. Maybe I am wrong. That is why we brought Blue Cross/Blue Shield here.

Let me ask you about the antitrust laws. As I recall, some members of the society indicated to me that the society, the Medical Society, had difficulty if it tried to persuade doctors—for example, a doctor who might be, from your point of view, out of line in what she charges—that the antitrust laws have indeed been applied against medical societies that try to bring its own membership into line; is that true?

Dr. ELLIS. To my understanding, it is. Any time doctors talk between themselves as individual operators with their own commercial entities, if you will, if they talk about cost data in some sort of way that influences what their costs will be, then that is against, to my understanding, what present antitrust law allows.

Ms. NORTON. So the Medical Society could not send out a memorandum saying the average cost of—I don't know—whatever ophthalmologists do, Dr. Whitten, the average cost; take one of your proceedings as x , and we are not telling you what to do, but the average cost is x .

Dr. WHITTEN. I think you are right. We cannot do that. I cannot tell people what I charge for a cataract operation, if you will. You are absolutely right.

Ms. NORTON. I wonder about a market system that does not allow people to even know whether or not they are in line with the cost practices in their profession in their area.

Dr. ELLIS. We are hoping, with the health care reform legislation, there will be alterations in the antitrust laws so that doctors

can really cooperate in networks, to negotiate with insurers and other third parties so that we can have a more rational network.

Ms. NORTON. Mrs. Morella.

Mrs. MORELLA. Thank you.

I want to thank you Dr. Ellis and Dr. Whitten for testifying. I have been trying to make a list as you testified about what your concerns are. They have to do with lack of knowledge of criteria; no one seems to know the providers, the doctors, the enrollees.

Timely notice, if one is no longer affiliated, timely notice.

Due process in general.

The appeal process.

Peer review.

I want to ask you, are all of those elements adhered to in other networks, with other HMO's? I want you to tell me, how does Blue Cross/Blue Shield in this arrangement with the SPPP differ from the other HMO's?

Dr. WHITTEN. I think you are absolutely right, those elements are found in other PPO's and HMO's. One of the main differences we found in SPPP was the way in which the plan was initiated; it was born full grown. Doctors found out they were no longer in the plan. Six months later they might receive a letter with some explanation as to what occurred, but it was totally unintelligible.

So we have a system that exists without—as we said before, without any look into the effects of the plan at all, no pilot programs. No demonstration occurred previously that would allow doctors and patients to understand what was occurring.

In fact, my office and my office staff are part of SPPP as their own insurance provider. Myself—you know, I even have SPPP as my insurance carrier, but I didn't know it. I didn't know it until I received a notice in the mail that I was now an SPPP patient because I was in the previous Blue Cross/Blue Shield program. So I was basically rolled into a program I knew nothing about. I opened the book and I couldn't even find myself, which meant my own staff couldn't be treated by me if they wanted to be part of SPPP.

So it is this type of program we are concerned about, we are not aware of this type of program occurring in other managed care settings.

Mrs. MORELLA. You are saying that doctors can also be rolled out of the system without recourse in terms of appeal when they find out that they are out?

Dr. WHITTEN. I have seen no written due process mechanism from Blue Cross.

Mrs. MORELLA. I do agree, though, in listening to Mr. Smith, who said he had not heard from any enrollees, that my question was, why has he not heard from the doctors involved in the system, you said the organization itself has not met with him. I guess individual doctors have not felt that they should.

Dr. WHITTEN. Individual doctors don't know enough, believe it or not, about all the mechanisms of government to say, well, obviously we should go to OPM. We are looking at Blue Cross. It is our own ignorance, if you will, on the way that government works that probably kept individual doctors from going to OPM.

Mrs. MORELLA. And I think, from your testimony, you have no problem with the concept of managed care or physicians care—

Dr. WHITTEN. I am in 10 or 15 managed care programs—Dr. Ellis is also—and I think physicians of all sorts are in managed care programs now. So it is not that type of thing we are complaining about.

Mrs. MORELLA. I get the implication, it is really cost based.

Dr. WHITTEN. I believe that from all the indications we have, from all the figures that we can glean from our materials that are supplied by Blue Cross—we don't have the computers so we don't have the answers, but cost appears to be the line that is drawn here.

Mrs. MORELLA. It will be very interesting to hear from Blue Cross/Blue Shield.

I thank you both for appearing.

Thank you.

Ms. NORTON. Thank you.

Mrs. Byrne.

Mrs. BYRNE. I have just a couple of quick questions.

Dr. Ellis, you indicated you were deselected and then reselected. That was in about a 6-month timespan?

Dr. ELLIS. Approximately, yes.

Mrs. BYRNE. Were there any of your patients at that time who said that because they now had to pay 25 percent instead of 10 percent, they could no longer see you?

Dr. ELLIS. No. I am glad you asked that. This is actually a somewhat complicated issue.

A lot of times, there is no clear-cut change because I already, if you will, participated with Blue Cross/Blue Shield, meaning that after the patient paid their 20 percent or whatever deductible, I would bill Blue Cross/Blue Shield and not make the patient bill Blue Cross/Blue Shield for the visit.

I think the average patient wouldn't do much when they see that—I am still covered by Blue Cross/Blue Shield; they have done something else called SPPP, but I guess I will just go on to my doctor and see what occurs.

They go to the doctor and he still takes Blue Cross. The only thing is, they don't have to pay but \$10. That is the way my office began to realize that we had to refund to some patients under Blue Cross; that is how I found out, because they have to pay just \$10. We automatically asked then, do you work for the Federal Government? And if you are in Blue Cross/Blue Shield in the Federal Government, we know only to collect \$10; otherwise, we collect too much and have to send some back. That increases the overhead that much more and makes my staff tear their hair out that much more, too.

But the point of the matter is, it is somewhat seamless to a patient. They don't see a big change. Our concern is, over time, that new doctors and/or new patients who come into the program will not have availability to each other, if you will, and we are concerned that it shouldn't occur because of the blunt edge of economic credentialing. We don't have a problem with credentialing doctors; we have a problem excluding doctors purely on cost.

Mrs. BYRNE. You are still deselected, Dr. Whitten. Do you have any indication that patients have made their choice of physician based on whether they are in SPPP or not?

Dr. WHITTEN. I have had only a few people say to me that they noticed I wasn't in the SPPP program and asked me why. But my patients, as is generally the case for an ophthalmologist, come back in 2 or 3 years, so an effect may be coming. I just don't know it yet.

Mrs. BYRNE. That is all I have.

Ms. NORTON. Thank you, Mrs. Byrne.

I want to thank both of you for taking time from what I know are busy practices, Blue Cross/Blue Shield notwithstanding, to come and testify this morning.

Your testimony has credibility for us because you do accept managed care, which I have to say to the profession, as you appear on the stand, is here to stay. A question is, what does it mean in individual instances? Your testimony has been very helpful in making us understand its implications.

Thank you.

Dr. WHITTEN. Thank you for your time.

Dr. ELLIS. Thank you.

Ms. NORTON. I would like to call Dr. Gregory Morris. Dr. Morris is senior vice president of and corporate medical director of Blue Cross/Blue Shield of the National Capital Area.

Let me put you at ease—although I am very concerned about what has happened here, I am equally concerned about the cost of health care and do not believe that universal coverage for all is going to be possible unless providers like Blue Cross/Blue Shield take steps to lower the cost of health care for those who are receiving it.

So you should not interpret my concern and that of the committee as hostile concern; indeed, we want to encourage as many efforts as possible to cut the cost of health care. So I compliment you for having that as a factor.

All we want to know is what it is all about and whether all of the factors that might be important have been considered.

I would be pleased to hear your testimony at this time. Your full testimony, of course, will be included in the record in any case.

STATEMENT OF GREGORY K. MORRIS, M.D., SENIOR VICE PRESIDENT AND CORPORATE MEDICAL DIRECTOR, BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA

Dr. MORRIS. Thank you very much, Madam Chairman. I appreciate the opportunity to speak with you today and to provide you information regarding Blue Cross/Blue Shield of the National Capital Area's Select PPP plan, or SPPP, which is part of the national preferred provider network available to Federal employees enrolled in the Blue Cross/Blue Shield service benefit plan.

The select PPP represents the leading-edge approach to managing health care costs for customers while providing them with access to quality care. Perhaps because it is leading-edge, there appear to be misunderstandings about the select PPP, as well as considerable misinformation being communicated about it by those who are not familiar with it. In the next few minutes, I hope to focus the discussion on the central issue concerning the select PPP, discuss that issue, and comment directly on some of the misunder-

standings and misinformation. I then will be available to answer your questions.

In January 1993, BCBSNCA introduced a newly developed PPO, the select preferred provider plan, to serve Federal employees in lieu of the previously used network, the PPP. Other than that change and certain enhancements that increased the differential between the in-network and out-of-network benefits, the program continued to operate essentially as it had since 1990.

When the select PPP was introduced in January 1993, there were 1,055 fewer providers in the select PPP than in the PPP. However, there were 1,400 more providers in the select PPP than had been in the PPP when it was first offered to Federal employees in 1990. In June 1993, BCBSNCA repeated the selection process, adding 619 providers and making the select PPP the largest network being promoted within our service area. The select PPP currently has a total of 6,243 providers, or 68 percent of all providers who participate with Blue Cross.

If you would look to the table in my statement, you will see it will demonstrate that in 1990 some 40 percent of 8,000 doctors were available to Federal employees on an in-network basis, that today more than 68 percent of the participating doctors are available to Federal employees on an in-network basis. That is an increase of more than 75 percent in the number of physicians available for Federal employees in the metropolitan area since the program was introduced in 1990. This is in the face of a less-than-10-percent increase in the Federal enrollment, by the way.

Since 1990, there has been only one fundamental change in the Blue Cross/Blue Shield plan available to local Federal employees: With the introduction of the select PPP, Blue Cross/Blue Shield of the National Capital Area developed criteria which were utilized in the establishment of the select PPP network.

The issue today is not about discrimination against providers or patients. While there have been insinuations of discrimination against certain providers and patients, discrimination based on sex, race, national origin and/or disability is wrong and Blue Cross does not participate in such activity. There is absolutely nothing contained in our methods of evaluation that could be conceived or perceived to be discriminatory.

The issue today is not about access to providers; as of this date, the select PPP has over 6,200 providers. That is 160 more providers than had served Federal employees under the previous PPO. Also, while this network includes more than half of all of the area's providers, they are contracted to serve approximately 15 percent of the area's total population. The selection methods we used to establish the network were specifically designed to ensure that adequate coverage would be available in all sectors of the District of Columbia and our service area as a whole. Patients have access to physicians across our entire service area.

The issue today is not about patient choice; every year, Federal employees in the Washington metropolitan area have an option to choose from at least 28 different health plans. Those employees who choose Blue Cross/Blue Shield standard or high option have the largest network of providers in this community available to them, and both options are designed to provide benefits whether

the subscriber chooses to seek services from a select PPP provider or from providers outside the network. Patients who choose to enroll in the service benefit plan have a choice each time they seek care whether to stay within the select PPP network; and within the network, they have a choice of which provider they will see.

The issue today is not about quality: the select PPP providers are practitioners who participate in other networks established by Blue Cross, as well as other health plans in the community. To be considered for the select PPP, a health care provider must be in BCBSNCA's participating provider network, which is used for Blue Cross traditional programs. All Blue Cross participating providers are subjected to credentialing and recredentialing, and must remain in good standing with area medical boards. Care provided by all Blue Cross participating providers, whether they are select PPP providers or not, is monitored by our quality management programs. Finally, as part of the selection process for the select PPP, there is an additional level of scrutiny by our utilization management and internal audit staffs. Providers in all of Blue Cross/Blue Shield National Capital Area networks, including the select PPP, are reviewed for quality.

Based on the considerations above, it appears difficult to understand how the concerns expressed by some of the providers who were not invited to join the Select PPP can be construed as being motivated by concern for patients' needs. In fact, the Blue Cross/Blue Shield Standard Option has been very popular with Federal employees, with more than 7,000 Federal employees, or 15,000 participants, including dependents, joining during the most recent open season.

If the issue today is not discrimination, not access to providers, not patient choice, and not quality, what is it? The issue is whether Blue Cross/Blue Shield National Capital Area has a right—and a responsibility—to choose the providers who participate in its networks. At Blue Cross/Blue Shield National Capital Area, we base our choice on objective information available to us about those providers. The measurement of practice patterns and the incorporation of these measurements into the provider selection process is appropriate, responsible, and in step with demands by employers, including the Federal Government, the requirements of accrediting agencies, and the direction of health care reform.

As the largest plan in the Federal Employees Health Benefits program, the Blue Cross/Blue Shield Service Benefit Plan has a responsibility not just to prepare for reform, but to help set the stage for successful reform initiatives. The Select PPP is certainly an important part of this effort. Not only must we provide access, patient choice, and quality care, but we must do all this with a watchful eye on cost as well. Blue Cross/Blue Shield National Capital Area believes that the best way to contain costs is to create incentives for consumers to use cost-effective health care plans, and this is well accomplished by the benefit design of the Service Benefit Plan and the network access of the Select PPP.

We are certainly not alone among insurers in offering our customers access to selected networks of health care providers; of the 28 health plans in the Federal Employees Health Benefits program open to all Washington employees in 1994, 18 are HMOs, and each

of the remaining 10 offers a PPO option. Options such as these are regarded by many experts as our best hope for restraining health care cost increases for consumers and payers alike.

It is interesting to note that some physicians support the principle of selective contracting. You may have seen news reports in the last week regarding a group of local physicians who are banding together to form their own health care network, Capital Area Physicians Network. In a report in the Washington Post, Dr. Daniel Ein, president, Capital Area Physicians Network, and a past president of the Medical Society of the District of Columbia, is quoted as saying that the group is enrolling doctors on an invitation-only basis, adopting its own variation of the exclusive postures other health plans have taken.

Medical Board actions, our own credentialing activities, and our quality assurance efforts all enhance the quality of care received by our subscribers. However, after identifying episodes of less than optimal care, additional differences in the quality of health care are not easily measured. Although the quality of care may vary little among fully credentialed physicians, physician practice patterns—such as how often physicians see patients for a given condition, what tests and how many tests they order, and how long they keep their patients in the hospital—vary significantly, even when adjustments are made for differences in the types and severity of patients' illnesses, patients' ages, and other factors. While there are differences in the charges by individual physicians, the impact of differences in their practice patterns eclipses the significance of those charge differences.

An exhibit on "Adult Primary Care Billings" is even more dramatic. There are some practices in this community that provide care for a group of 1,600 patients with an average total resource consumption of \$234,800 on an annual basis, while there are other practices that provide care for a comparable group of patients, over a comparable time period, with comparable quality, at nearly five times the resource consumption, at \$1,210,800.

What do patients and employers get for the additional resources consumed as a result of these variations in practice patterns?

As the exhibit on "Cost, Quality and Outcome" illustrates, medical care tends to fall on a continuum of costs and quality. Quality is defined here by outcome, including morbidity, mortality, and patient satisfaction.

What do patients and employers get for additional resources consumed as a result of these variations in practice patterns? Every since I trained in internal medicine, I have continued to be impressed that doing the right thing the first time improved care and cost less in the long run. There is broad agreement that when inadequate resources are used, quality suffers. When too many resources are brought to bear, quality may also suffer. Our focus is on the range where, for equal or immeasurable differences in quality, a broad range of health care services is consumed. Our objectives are to focus on this broad range of resource consumption and to minimize those differences where there is no contribution to enhancement of care.

The selection process used to develop the Select PPP takes advantage of our ability to objectively document the differences in

physicians' practice patterns. However, the database from which we extract this information also includes data important in the evaluation of quality and outcomes of care.

The exhibit on "Lung Cancer" represents a number of hospitals in the Washington metropolitan area. AA and EA represent two hospitals in our community recognized for a high level of care for patients with cancer. Note also that, in fact, they provide care at a lower rate of total resource consumption than others in the community.

One final exhibit demonstrates the relationship between total resource consumption and the experience of the physician, as measured by the number of laparoscopic cholecystectomies—gall bladder surgeries—performed by each surgeon in an 18-month period. The total average resource consumption for physicians with more experience is significantly less than the average resource consumption generated by physicians with less experience. A likely explanation for this phenomenon is that those with greater experience tend to have fewer complications, tend to use fewer consultants, and have a greater ability to know the right time to discharge the patient, for example. This phenomenon contradicts the misbelief that physicians who get more difficult patients appear to be less cost-effective.

One interesting source of perceived quality and performance comes from the list of "Top Doctors" identified in the October and November 1993 issues of Washingtonian magazine. The magazine listed the top vote-getters from a survey of 3,700 randomly selected physicians in the Baltimore-Washington area who were asked who they would turn to if they or a family member needed care in any of 30 specialties. The article points out that the doctors listed are not necessarily the best doctors, and that many first-rate doctors are not on the list, yet it serves as one indication of local physicians who are esteemed by their peers. Of the 980 doctors listed, 754 participate with BCBSNCA, and 561—74 percent of those who participate—are in the Select PPP.

Of the 30 doctors who received the most votes in each of the 30 specialties, we were able to evaluate 18 of them. Seven were not evaluated because they did not participate with Blue Cross, four were in a university faculty practice or specialty which was evaluated differently, and we had insufficient data for one. Of the 18 evaluated, 78 percent were in the top half of our rankings, and 61 percent were in the top quarter. Eleven percent actually ranked first in their specialties. Of these top 30 doctors, 21 were included in the Select PPP.

These results obviously are not consistent with protestations that BCBSNCA's selection process identified physicians who simply cut corners. It is difficult to believe that those who are unhappy with the Select PPP are prepared to document that physicians who were selected, who comprise 68 percent of all participating physicians, are inferior to those 32 percent who were not selected.

It is also important to note that differences in practice patterns are only one factor in our selection process. The key here is the focus on physician performance, credentials, access, and capacity.

An appeal process was established to review cases of providers who were not invited but who wanted to pursue participation in

the Select PPP. Approximately 550 providers took advantage of that process. Additional information presented in the appeal resulted in invitations to some of these providers.

We need to and will do more to raise providers' awareness and understanding regarding differences in their practice patterns. As a start, last year we mailed to every participating practice for which we had sufficient experience and data—including those providers not included in the Select PPP—a unique report which graphically portrayed the differences in practice patterns and the providers' own relative position in the distributions.

The learning curve regarding this matter is steep; no single document or meeting can affect the necessary changes. Multiple efforts over time will be required to allow providers to become more attuned to their practice habits and to routinely consider the cost and quality implications of their actions. BCBSNCA has a long history of working cooperatively with local providers for the benefit of our customers who are their patients. We will continue this cooperative process.

In the meantime, BCBSNCA, through the Federal Employee Program, offers to local Federal employees a program which allows them to choose the Select PPP, to choose whether to seek care in the network or outside of the network, and if within the network, to choose which provider from among many to visit.

Thank you.

[The prepared statement of Dr. Morris follows:]

PREPARED STATEMENT OF GREGORY K. MORRIS, M.D., SENIOR VICE PRESIDENT AND CORPORATE MEDICAL DIRECTOR, BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA

I appreciate the opportunity to provide you with information on Blue Cross and Blue Shield of the National Capital Area's Select Preferred Provider Plan, or Select PPP, which is part of the national preferred provider network available to federal employees enrolled in the Blue Cross and Blue Shield Service Benefit Plan. The Select PPP represents a leading edge approach to managing health care costs for customers while providing them with access to quality care. Perhaps because it is leading edge, there appear to be misunderstandings about the Select PPP, as well as considerable misinformation being communicated about it by those who are not familiar with it. In the next few minutes, I hope to focus the discussion on the central issue concerning the Select PPP, discuss that issue, and comment directly on some of the misunderstandings and misinformation. I then will be available to answer your questions.

In the 1980s, in response to customers' demands for programs that slowed rapidly rising health care costs, Blue Cross and Blue Shield Plans, along with other insurers, began to develop Preferred Provider Organizations (PPOs), as well as other types of managed care programs. These PPOs typically gave patients incentives to use certain hospitals and physicians with which the Plan had negotiated lower fees.

As Blue Cross and Blue Shield Plans developed these PPOs to serve their private business, the Blue Cross and Blue Shield Association's Federal Employee Program Director's Office encouraged the local Blue Cross and Blue Shield Plans to offer preferred provider "overlay" programs to federal employees in their geographic areas. These programs preserved the existing federal benefits package, while giving subscribers the opportunity to reduce their out-of-pocket expenses when they received care from preferred providers. The overlay plans were structured so that by using preferred providers, subscribers' benefits were enhanced, rather than being penalized for not using preferred providers. This principle of enhancing benefits rather than imposing penalties has remained a central feature of the Blue Cross and Blue Shield Federal Employee Program's preferred provider program.

In 1993, the Blue Cross and Blue Shield Federal Employee Program expanded these earlier efforts by introducing a nationwide PPO, based on the preferred provider organization established by local Blue Cross and Blue Shield Plans. With all Blue Cross and Blue Shield Plans offering access to their PPOs, the Federal Em-

ployee Program was able to enhance the preferred provider benefit significantly. Subscribers continued to have the freedom to seek care from providers outside the network; when they did, they received essentially the same benefits they had received in the past.

Locally, Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) first offered a PPO to Standard Option and High Option federal subscribers in 1990. Most of our federal subscribers have chosen the Standard Option. Under Standard Option, subscribers had been responsible for paying 25% of usual, customary or reasonable fees for physicians' services, once their yearly deductible had been satisfied. This benefit did not change. However, subscribers also had the option of using a preferred provider. When they did, their share of the expenses was 20% of the preferred provider allowance, once the deductible had been satisfied. The PPO available to federal employees at that time, developed and managed by BCBSNCA, was called the Preferred Provider Plan (PPP). It contained 3,570 providers who: (1) were among more than 8,200 providers already participating with BCBSNCA; and (2) chose to join the PPP by accepting a new schedule of maximum allowances. Approximately 444,000 federal employees and their dependents were served by the network in 1990.

By the end of 1992, the PPP network had grown to 6,083 providers. In January 1993, BCBSNCA introduced a newly developed PPO, the Select Preferred Provider Plan (Select PPP), to serve federal employees in lieu of the previously used network, the PPP. Other than that change, and certain enhancements that increased the differential between the in-network and out-of-network benefits, the program continued to operate essentially as it had since 1990.

When the Select PPP was introduced in January 1993, there were 1,055 fewer providers in the Select PPP than in the PPP. However, there were 1,400 more providers in the Select PPP than had been in the PPP when it was first offered to federal employees in 1990. In June 1993, BCBSNCA repeated the selection process, adding 619 providers and making the Select PPP the largest network being promoted within our service area. The Select PPP currently has a total of 6,243 providers, or 68% of all providers who participate with BCBSNCA.

Providers in the PPP—1/90	3,570
Providers in the PPP—12/92	6,083
Providers in the Select PPP—1/93	5,028
Providers in the Select PPP—6/93	5,647
Providers in the Select PPP—6/94	6,243

Since 1990, there has been only one fundamental change in the Blue Cross and Blue Shield plan available to local federal employees: with the introduction of the Select PPP, BCBSNCA developed criteria which were utilized in the establishment of the select PPP network.

The issue today is not about discrimination against providers or patients: while there have been insinuations of discrimination against certain providers and patients, discrimination based on sex, race, national origin and/or disability is wrong and BCBSNCA does not participate in such activity. There is absolutely nothing contained in our methods of evaluation that could be conceived or perceived to be discriminatory.

The distribution of Select PPP physicians throughout the District of Columbia is close to the distribution of Blue Cross and Blue Shield Participating physicians. For example, of the 132 physicians practicing in Southeast Washington who have chosen to participate with BCBSNCA, 87, or 66%, are in the Select PPP network. This proportion is approximately the same as in the Washington metropolitan area as a whole.

The issue today is not about access to providers: as of this date, the Select PPP has over 6,200 providers. That is 160 more providers than had served federal employees under the previous PPO. Also, while this network includes more than half of all of the area's health care providers, they are contracted to serve approximately 15% of the area's total population. The selection methods we used to establish the network were specifically designed to ensure that adequate coverage would be available in all sectors of the District of Columbia and our service area as a whole. Patients have access to physicians across BCBSNCA's entire service area.

The issue today is not about patient choice: every year, federal employees in the Washington metropolitan area have an option to choose from at least 28 different health plans. Those employees who choose Blue Cross and Blue Shield Standard or High Option have the largest network of providers in this community available to them, and both Options are designed to provide benefits whether the subscriber chooses to seek services from Select PPP providers or from providers outside the network. Patients who choose to enroll in the Service Benefit Plan have a choice

each time they seek care whether to stay within the Select PPP network, and within the network, they have a choice of which provider they will see.

The issue today is not about quality: the Select PPP providers are practitioners who participate in other networks established by BCBSNCA, as well as other health plans in the community. To be considered for the Select PPP, a health care provider must be in BCBSNCA's Participating Provider network, which is used for BCBSNCA's traditional programs. All BCBSNCA Participating providers are subjected to credentialing and recredentialing, and must remain in good standing with area medical boards. Care provided by all BCBSNCA Participating providers, whether they are Select PPP providers or not, is monitored by our quality management programs. Finally, as part of the selection process for the Select PPP, there is an additional level of scrutiny by our Utilization Management, Quality Management and Internal Audit staffs. Providers in all of BCBSNCA's networks, including the Select PPP, are reviewed for quality.

Based on the considerations above, it appears difficult to understand how the concerns expressed by some of the providers who were not invited to join the Select PPP can be construed as being motivated by concern for patients' needs. In fact, the Blue Cross and Blue Shield Standard Option has been very popular with local federal employees. During the 1993 Open Season, we had a local net gain in enrollment of more than 7,000 federal employees, or over 15,000 participants, including dependents. The choice exercised by federal employees occurred after they had been provided with specific information regarding the identity of Select PPP physicians, as well as the enhanced benefits they would receive when using these providers.

If the issue today is not discrimination, not access to providers, not patient choice, and not quality, what is it? The issue is whether BCBSNCA has a right—and a responsibility—to choose the providers who participate in its networks. At BCBSNCA, we base our choice on objective information available to us about those providers. The measurement of practice patterns and the incorporation of these measurements into the provider selection process is appropriate, responsible and in step with demands by employers, including the federal government, the requirements of accrediting agencies, and the direction of health care reform.

As the largest plan in the Federal Employees Health Benefits program, the Blue Cross and Blue Shield Service Benefit Plan has a responsibility not just to prepare for reform, but to help set the stage for successful reform initiatives. The Select PPP is certainly an important part of this effort. Not only must we provide access, patient choice and quality care, but we must do all this with a watchful eye on cost as well. BCBSNCA believes that the best way to contain costs is to create incentives for consumers to use cost-effective health care plans, and this is well accomplished by the benefit design of the Service Benefit Plan and the network access of the Select PPP.

We are certainly not alone among insurers in offering our customers access to selected networks of health care providers; of the 28 health plans in the Federal Employees Health Benefits (FEHB) program open to all Washington area federal employees in 1994, 18 are HMOs, and each of the remaining 10 offers a PPO option. Managed care options such as these are regarded by many experts as our best hope for restraining health care cost increases for consumers and payers alike. I have included for the record a report titled "New Evidence on Savings from Network Models of Managed Care," prepared by the consulting firm Lewin-VHI, that analyzed the savings achieved by several types of managed care plans, including PPOs.

It is interesting to note that some physicians support the principle of selective contracting. You may have seen news reports in the last week regarding a group of local physicians who are banding together to form their own health care network, Capital Area Physicians Network. In a report in The Washington Post, Dr. Daniel Ein, president Capital Area Physicians Network and a past president of the Medical Society of D.C., is quoted as saying that the group is enrolling doctors on an invitation-only basis, adopting its own variation of the exclusive postures other health plans have taken.

Medical board actions, our own credentialing activities, and our quality assurance efforts all enhance the quality of care received by our subscribers. However, after identifying episodes of less than optimal care, additional differences in the quality of health care are not easily measured. Although the quality of care may vary little among fully credentialed physicians, physician practice patterns—such as how often physicians see patients for a given condition, what tests and how many tests they order, and how long they keep their patients in the hospital—vary significantly, even when adjustments are made for differences in the types and severity of patients' illnesses, patients' ages and other factors. While there are differences in the charges by individual physicians, the impact of differences in their practice patterns eclipses the significance of those charge differences.

I have included several examples of these differences in practice as part of my testimony. The exhibit on "Coronary Artery Bypass Grafts" using 1990-1991 data demonstrates a wide range in resources used within this community for this type of heart surgery. In looking at practices at the 5th and 95th percentiles of resource use, we can see that some practices in the community provide this care at a total resource consumption averaging \$27,110 per case for all care, while others care for their patients at an average total resource consumption averaging \$74,565 per case, more than a three-fold difference.

An exhibit on "Adult Primary Care Billings" is even more dramatic. There are some practices in this community that provide care for a group of 1,600 patients with an average total resource consumption of \$234,800 on an annual basis, while there are other practices that provide care for a comparable group of patients, over a comparable time period, with comparable quality, at nearly five times the resource consumption, at \$1,210,800.

33512 -- CORONARY ARTERY BYPASS GRAFT, THREE VESSEL

	# ADM	MEAN	P5	P10	P25	P50	P75	P90	P95
PROF:	182	\$12,017	\$ 7,210	\$ 7,963	\$ 9,036	\$10,684	\$12,302	\$15,030	\$19,103
HOSP:	182	\$33,451	\$15,244	\$18,269	\$20,565	\$23,977	\$29,929	\$40,959	\$56,250
TOTAL:	182	\$45,468	\$24,656	\$27,110	\$29,751	\$34,128	\$41,982	\$55,873	\$74,565
LOS:		12.31	5	6	7	9	11	16	24

SOURCE: BCBSNCA 1/1/90 - 6/30/91 -- PROPRIETARY & CONFIDENTIAL
 Compiled with the Pro/FileSM System

ADULT PRIMARY CARE BILLINGS

Est./Non Hosp. Pts.

<i>Age Group</i>	<i>No. of Patients</i>	<i>Average \$</i>	<i>10th %ile \$</i>	<i>90th %ile \$</i>
<i>18-35</i>	<i>400</i>	<i>104,400</i>	<i>40,000</i>	<i>191,200</i>
<i>35-45</i>	<i>400</i>	<i>148,400</i>	<i>53,200</i>	<i>272,400</i>
<i>45-55</i>	<i>400</i>	<i>195,200</i>	<i>66,400</i>	<i>360,800</i>
<i>55-65</i>	<i>400</i>	<i>214,800</i>	<i>75,200</i>	<i>386,400</i>
	<i>1600</i>	<i>662,800</i>	<i>234,800</i>	<i>1,210,800</i>
<i>Assume panel of 1600 patients equally distributed among 4 age groups.</i>				

DATA COMPILED WITH THE PRO/FILESM SYSTEM

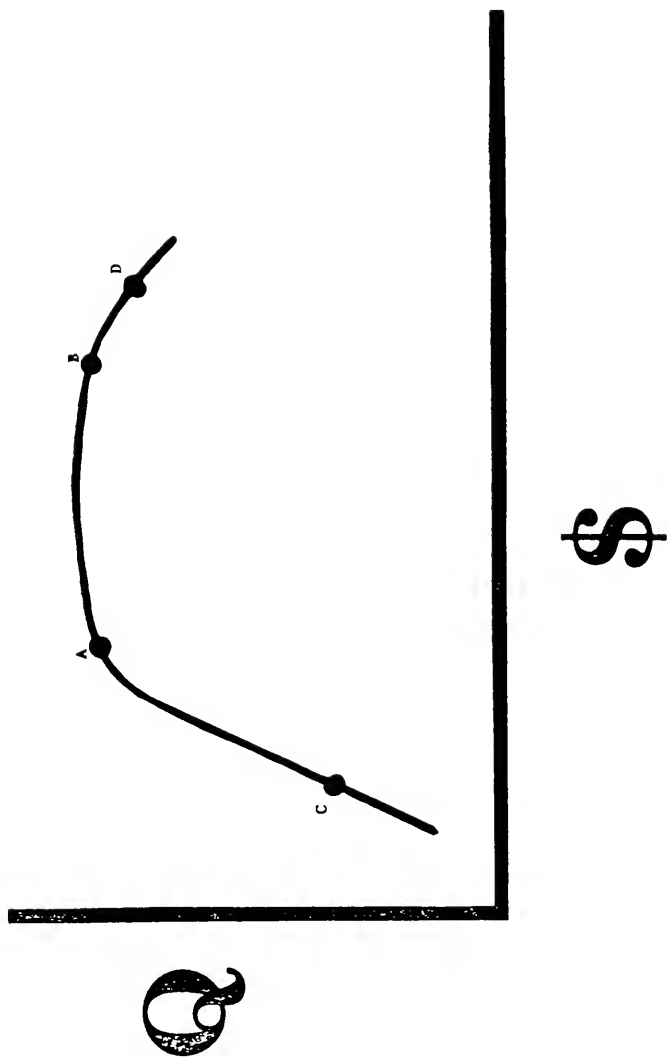
What do patients and employers get for the additional resources consumed as a result of these variations in practice patterns?

As the exhibit on "Cost, Quality and Outcome" illustrates, medical care tends to fall on a continuum of costs and quality. Quality is defined here by outcome, including morbidity, mortality and patient satisfaction.

When I trained in Internal Medicine, I was always impressed that doing it right the first time improved care and cost less in the long run. There is broad agreement that when inadequate resources are used, quality suffers (Point C). When too many resources are brought to bear, quality may also suffer (Point D). Our focus is on the range where, for equal or immeasurable differences in quality, a broad range of health care services is consumed (Points A-B). Our objectives are to focus on this broad range of resource consumption and to minimize those differences where there is no contribution to enhancement of care.

The selection process used to develop the Select PPP takes advantage of our ability to objectively document the differences in physicians' practice patterns. However, the database from which we extract this information also includes data important in the evaluation of quality and outcomes of care.

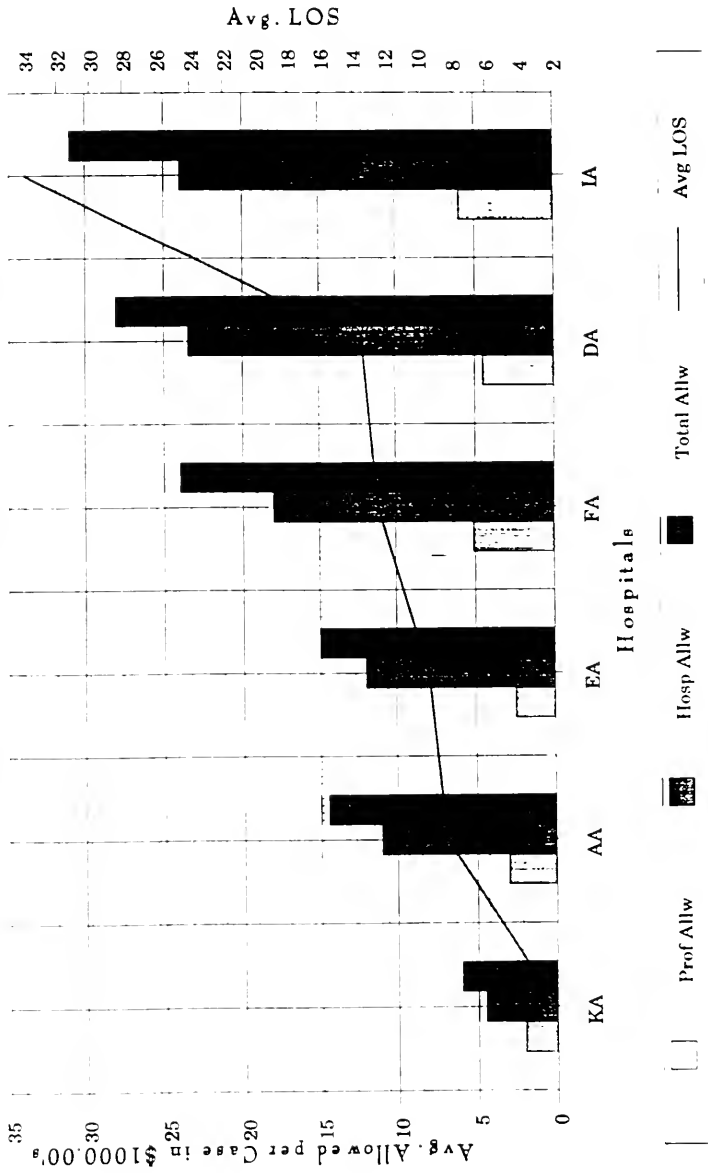
COST vs QUALITY & OUTCOME



The exhibit on "Lung Cancer" represents a number of hospitals in the Washington metropolitan area. AA and EA represent two hospitals in our community recognized for a high level of care for patients with cancer. Note also that, in fact, they provide care at a lower rate of total resource consumption than others in the community.

Lung CA

Jurisdiction "A" Hospitals 1/90 - 6/91



One final exhibit demonstrates the relationship between total resource consumption and the experience of the physician, as measured by the number of laparoscopic cholecystectomies—gall bladder surgeries—performed by each surgeon in an 18-month period. The total average resource consumption for physicians with more experience is significantly less than the average resource consumption generated by physicians with less experience. A likely explanation for this phenomenon is that those with greater experience tend to have fewer complications, tends to use fewer consultants, and have a greater ability to know the right time to discharge the patient, for example. This phenomenon contradicts the misbelief that physicians who get more difficult patients appear to be less cost-effective.

**DEMONSTRATION OF THE RELATIONSHIP BETWEEN
TOTAL RESOURCE CONSUMPTION AND THE NUMBER OF
PROCEDURES PERFORMED BY THE SURGEON**

LAPROSCOPIC CHOLECYSTECTOMIES -- 1 9 9 1				
NUMBER OF PROCEDURES PERFORMED BY SURGEON DURING 18 MONTH PERIOD		≥10	5-9	1-4
TOTAL RESOURCES (\$) PER:				
	SURGEON	2,150	2,080	2,055
	EPISODE	8,696	10,352	10,453
	ADMISSION	7,843	8,633	9,587
	HOSPITAL	4,635	4,918	5,780
	TOTAL PHYSICIAN	3,207	3,714	3,807
LENGTH OF STAY		1.7	2.7	2.8

DATA COMPILED WITH THE PRO/FILESM SYSTEM

One interesting source of perceived quality and performance comes from the list of "Top Doctors" identified in the October and November 1993 issues of *Washington Magazine*. The magazine listed the top vote-getters from a survey of 3,700 randomly selected physicians in the Baltimore-Washington area who were asked who they would turn to if they or a family member needed care in any of 30 specialties. The article points out that the doctors listed are not necessarily the "best" doctors, and that many first-rate doctors are not on the list, yet it serves as one indication of local physicians who are esteemed by their peers. Of the 980 doctors listed 754 participate with BCBSNCA, and 561—74 percent of those who participate—are in the Select PPP.

Of the 30 doctors who received the most votes in each of the 30 specialties, we were able to evaluate 18 of them. (Seven were not evaluated because they did not participate with BCBSNCA, four were in a university faculty practice or specialty which was evaluated differently, and we had insufficient data for one.) Of the 18 evaluated, 78 percent were in the top half of our rankings, and 61 percent were in the top quarter. Eleven percent actually ranked first in their specialties. Of these top 30 doctors, 21 were included in the Select PPP.

These results obviously are not consistent with protestations that BCBSNCA's selection process identified physicians who simply cut corners. It is difficult to believe that those who are unhappy with the Select PPP are prepared to document that physicians who were selected, who comprise 68 percent of all participating physicians, are inferior to those 32 percent who were not selected.

It is also important to note that differences in practice patterns are only one factor in our selection process. The basic steps in the selection of providers were as follows:

1. We evaluated the practice patterns of participating providers, including primary care physicians and most specialties. In doing so, we did not introduce external practice standards or apply our own standards; we only compared physicians relative to their peers practicing in the same specialty. The evaluation system BCBSNCA uses, the ProFilesm System, licensed to us by Health Services Analysis Inc., stratifies data so that we can compare treatment of patients with similar characteristics.
2. We then merged practice pattern and performance data with quantitative information based on years of training and experience, and, when applicable, board certification in the evaluated specialty.
3. Before selecting providers, additional consideration was given to the distribution of patients among geographic areas and among practices. Also considered was provider distribution among specialties within defined geographic areas. This step provides for uniform access requirements, helping to ensure that patients have access to the right mix of specialists and subspecialists. It also helps to account for differences in characteristics of patients who reside within defined geographic areas.

Not all specialties were evaluated; in those cases, providers were allowed to participate through an interim agreement. There are other categories in which practice pattern evaluation was not a criteria for participation at this time.

An appeal process was established to review cases of providers who were not invited but who wanted to pursue participation in the Select PPP. Approximately 550 providers took advantage of that process. Additional information presented in the appeal resulted in invitations to some of these providers.

We need to and will do more to raise providers' awareness and understanding regarding differences in their practice patterns. As a start, last year we mailed to every participating practice for which we had sufficient experience and data—including those providers not included in the Select PPP—a unique report which graphically portrayed the differences in practice patterns and the providers' own relative position in the distributions.

The learning curve regarding this matter is steep; no single document or meeting can affect the necessary changes. Multiple efforts over time will be required to allow providers to become more attuned to their practice habits and to routinely consider the cost and quality implications of their actions. BCBSNCA has a long history of working cooperatively with local providers for the benefit of our customers who are their patients. We will continue this cooperative process.

In the meantime, BCBSNCA, through the Federal Employee Program, offers to local federal employees a program which allows them to choose the Select PPP, to choose whether to seek care in the network or outside of the network, and if within the network, to choose which provider from among many to visit.

**NEW EVIDENCE ON SAVINGS FROM NETWORK
MODELS OF MANAGED CARE**

Submitted to:

The Healthcare Leadership Council

Prepared by:

David C. Stapleton, Ph.D.

Lewin-VHI, Inc.

May 5, 1994

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EXECUTIVE SUMMARY

President Clinton's health reform proposal, the Health Security Act, as well as other major reform proposals, rely on expansion of managed care to help control the growth of health care spending. Network models of managed care -- preferred provider organizations (PPOs), point-of-service (POS) plans, independent practice associations (IPAs), and numerous hybrids -- rather than group and staff model health maintenance organizations (HMOs) -- are likely to dominate future expansion of managed care, just as they have dominated recent expansion.

The Congressional Budget Office (CBO), which is responsible for "scoring" health care reform proposals that appear before Congress, credits network models of managed care with only very small savings. The conclusion that network models provide limited savings supports the views of those who favor other methods of controlling health spending, such as global budgeting and price controls. There is, however, a widening consensus that this conclusion is wrong -- that network models of managed care can and do produce substantially more savings than they have been given credit for in the past.

The Healthcare Leadership Council commissioned Lewin-VHI to examine readily available data from three major insurance companies -- Aetna, Humana, and Prudential -- for evidence on this issue. Our findings are presented in this report.

The estimation of cost savings from managed care is notoriously difficult. Direct comparisons of insurer costs under existing managed care plans to costs under existing fee-for-service (FFS) plans are inadequate because of biased risk selection -- managed care enrollees are typically healthier than FFS enrollees -- and because of differences in benefits -- managed care plans typically cover more services and require fewer out-of-pocket expenditures from enrollees.

Faced with these and other problems, and given the need to limit our analysis to an examination of readily available data, we developed separate study designs for each participating insurer. Using data provided by Aetna's actuaries, we were able to compare IPA, POS, and PPO costs to FFS costs, controlling for biased risk selection, benefit differences, and other factors. Direct comparisons of this sort were not possible with readily available data from either Humana or Prudential. Instead, we looked for more indirect evidence of the potential for cost savings from managed care by examining the importance of various features of network managed care plans in controlling costs. A better understanding of why some plans are more successful than others is needed in order to predict the effects of future expansion of managed care on costs. Our most significant findings are discussed below.

In 1992, Aetna's IPA costs were 23 percent lower than costs for their traditional FFS plans after adjusting for differences in risk selection, benefits, administrative costs, and location.

We estimate that in 1992 Aetna's IPA costs were 23 percent lower than costs for their traditional FFS plans after adjusting for differences in risk selection, benefits, administrative costs, and location. This difference represents real savings to plan members and their employers relative to their costs had they been enrolled in Aetna's traditional FFS plan.

This finding is based on estimates of medical, administrative, and out-of-pocket costs obtained from Aetna's actuarial models. The actuarial models reflect recent claims costs, administrative costs, and out-of-pocket expense experience for each product type (IPA, POS, PPO, or FFS) and take into account the age/gender composition of plan enrollees, benefits, firm size and market area.

A particular strength of this approach is that it allows us to control very precisely for benefit differences that have confounded other research efforts. Our estimates for all plans are based on coverage for the same set of services, and take into account differences in out-of-pocket expenditures that are expected because of differences in deductibles, coinsurance, and copays.¹ The fact that IPA plans generally cover more services (e.g., preventive care) and have lower out-of-pocket costs than FFS plans has been fully taken into account, and this may help explain why our estimated savings are substantially higher than those found in many early studies.

Aetna relies on its actuarial models to price its products for employer groups; thus, they have met a market test for accuracy. There is, nevertheless, reason for some skepticism about the validity of savings estimated on the basis of the actuarial models alone. In particular, it is likely that cross-product comparisons of the actuarial cost estimates will reflect historical biased risk selection. We examined the literature on this subject and concluded that the bias for IPAs relative to FFS plans could be on the order of five percentage points after controlling for factors that are already accounted for by the actuarial models.

For this reason, we reduced the 28 percent savings estimated by the actuarial models by five percentage points and report the resulting 23 percent figure as our point estimate of IPA savings. This deduction is based on an assessment of earlier research. It may, in fact, be too high. Aetna's actuaries argue that biased risk selection is more limited in their plans than in the

¹In principle, percentage savings could depend on the extent of coverage, even if coverage is the same under both plans, we estimated savings under two substantially different coverage specifications. In fact, our findings were almost identical for the two specifications.

plans analyzed in the literature, and that the appropriate adjustment is no more than one percentage point. Their arguments have some merit, and our deduction may be too conservative.

The estimated 23 percent savings for IPAs could overestimate the potential savings from replacing FFS plans with IPA plans, for two reasons. First, the savings reported include savings from utilization review (UR). Unlike the "traditional" FFS referred to above, many FFS plans in place today, including a popular Aetna plan, make extensive use of UR to control costs. Aetna's standard set of UR procedures alone reduces FFS costs by about four percent. Thus, in comparison to Aetna's typical "managed indemnity" plan, real IPA savings are four percentage points less, or about 19 percent.

Second, a large share of savings is due to discounts that Aetna obtains for its IPA members, but not its FFS members, from participating hospitals and physicians. Nationwide, hospital discounts account for about 10 percentage points of the average savings and physician discounts account for another five, for a total of 15 percentage points. Discount savings are real savings to the IPA members, but are not necessarily savings to the health care system as a whole because providers may "shift" costs for IPA members onto FFS customers through higher charges.

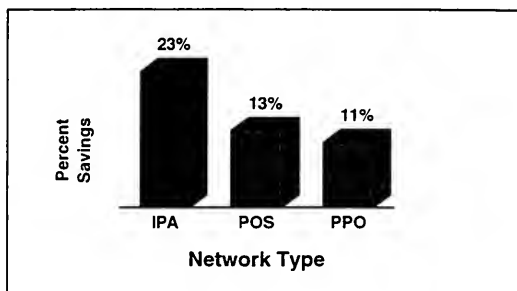
While it is not possible to estimate how much of the discount savings represents real system savings with any degree of precision, we believe that system savings are large -- 10 percentage points, if not more. System savings occur in large part because IPAs stimulate price competition among providers; hospitals and physicians must either become more efficient in their delivery of care or accept lower earnings in order to obtain patients. System savings are even higher if providers respond by adopting more efficient practice patterns for all of their patients, as could well be the case.

Deducting four percentage points for UR savings and another five percentage points for cost shifting leaves system savings for IPAs, relative to managed indemnity, of 14 percent. This is substantially greater than both the savings estimates found in all but the most recent studies and those used by CBO. Of course this result does not necessarily generalize to other IPAs, and many factors must be taken into account in the process of translating a finding such as this into managed care cost savings for a particular health reform proposal. Nonetheless, this finding provides reasons for optimism about obtaining substantial savings from the further promotion of managed care.

Aetna's POS plans achieved real savings of 13 percent relative to traditional FFS plans, and Aetna's PPO plans achieved real savings of 11 percent.

Using the same methodology as for IPA plans, we find that Aetna's POS plans saved 13 percent relative to traditional FFS plans, and their PPO plans saved 11 percent (Exhibit ES.1). As with the IPA estimates, these estimates reflect adjustments for biased risk selection.² UR savings and discount savings are also included.

EXHIBIT ES.1
Percentage Savings from Managed Care
Relative to Fee-for-Service



The findings for POS plans have an important implication for the Health Security Act (HSA). As submitted to Congress, the HSA requires all managed care plans to offer coverage for non-emergency out-of-network services. Of the plans considered here, the POS plan is the most restrictive plan that includes coverage of any sort for such services. Comparison of our finding of 23 percent savings for IPAs to 13 percent savings for POS plans suggests that this HSA provision may substantially reduce the potential of managed care to yield significant savings under health reform -- especially since it applies to millions of IPA and HMO members who do not currently have an out-of-network option.

Alain Enthoven argues that the potential for managed care to reduce growth in health care spending has not yet been realized, despite rapid expansion of managed care, because under the current system the main purchasers of private health insurance, namely employer groups, are not very sensitive to price.³ As a result, managed care plans compete with

²The adjustments made are smaller than the five percentage point IPA adjustment because patients under these plans have considerably greater discretion in their choice of providers and their utilization of care. We deducted three percentage points for POS plans and two for PPO plans.

³See Alain C. Enthoven, "Why Managed Care Has Failed to Contain Health Costs," *Health Affairs*, Fall 1993, pp. 27 - 43.

indemnity plans by offering better benefits at the same price rather than the same benefits at a lower price. This may explain why our findings of managed care savings, which carefully control benefits, exceed those found in many earlier studies. It also suggests that if health care reform encourages price competition, realized savings could be even greater than the savings found here.

Two additional findings from our study provide significant weight to Enthoven's argument. The first is the finding of great variation in savings among plans of a given type, which provides evidence of both limited price competition currently and substantial scope for increased savings under health reform that encourages price competition. The second is the finding that primary care physicians with many patients from a single IPA have lower costs per enrollee than those with just a few, indicating that increasing IPA volume (IPA members per primary care physician) above the low level found in many current IPAs would significantly reduce costs. This is one way that IPAs might achieve greater savings under increased price competition. These findings are discussed further below.

Some IPAs produce savings which are almost three times as great as those of other IPAs in the same company, and similar savings variation is found for POS and PPO plans. This is evidence of both the limits of price competition today and the scope for increased savings under health reform if reform is designed to encourage price competition.

Savings for Aetna's IPA, POS, and PPO plans were estimated in each of 26 different market areas, by comparing the plan's cost in the market area to cost for Aetna's FFS plan in the same area.⁴ For IPAs, we found savings as high as 34 percent in one market area and as low as 12 percent in another; a few other markets had savings near these extremes. Savings for POS plans ranged from one percent to 24 percent, and savings for PPO plans ranged from a negative one percent (i.e., higher costs) to 20 percent.⁵

We also examined variation in per member per month medical costs across market areas for Humana PPO and IPA plans and for Prudential IPA and POS plans after adjusting for demographic factors and market area medical prices; for Humana, we were also able to adjust for cross-market variation in benefits. Substantial remaining variation was found across market areas for each plan type and for each insurer. While some of this variation is due to imperfect

⁴ The savings percentages reported earlier for each plan type are averages over savings from plans of that type in the 26 areas.

⁵The IPA estimates use a five percentage point reduction for biased risk selection, the POS estimates use a three point reduction, and the PPO estimates use a two point reduction. No reduction has been made for UR or discount savings.

adjustments for demographics, market factors, and benefit factors, a substantial share of this variation is no doubt due to variation in the insurers' success in achieving their goals, as the insurers themselves would argue.

The magnitude of cross-market variation in savings or costs found for each insurer is all the more remarkable because it is variation across plans that all belong to a single company. Each one of these companies is attempting to adopt its best management practices in all of its market areas. Thus, the nationwide management of each insurer exerts a moderating influence on the cross-market variation in savings and costs for its plans.⁶ Were we able to examine variation in savings or costs across insurers for each type of plan, we would probably find even greater variation.

These findings demonstrate the limits of price competition today. In a market in which price competition was more important, plans that produce low savings would lose their members to the competition. The findings also show that there is substantial room for further increases in managed care savings. Increased price competition would encourage plans to adopt the management practices that have already been adopted by those plans which are currently saving the most.

The HSA has some features that would encourage price competition among insurers. Thus, under the HSA some managed care savings could be greater than our estimates of current savings suggest.

We find substantial evidence to support the hypothesis that expansion of IPA volume (the number of patients a primary care physician has who are members of the IPA) can significantly reduce IPA costs.

Managers at all three insurers told us that they could not "get the attention" of network physicians and influence their behaviors unless the physician had at least 100 patients who were IPA members. Analysis of individual primary care physician data provided by Humana yielded evidence that was strongly consistent with the claims made by the managers. The negative relationship between volume and cost was corroborated by market level evidence from both Humana and Prudential.

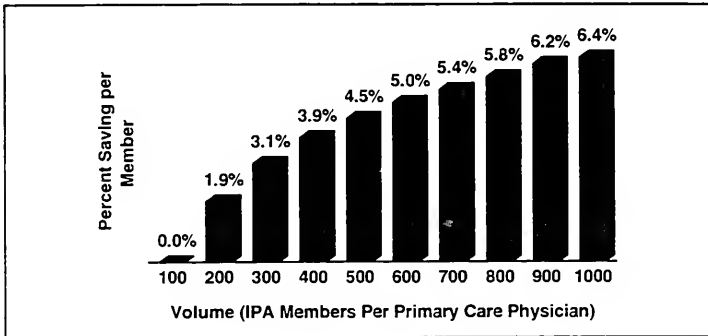
The analysis of the Humana physician data showed a statistically significant, negative relationship between volume and cost per member for specialty and hospital care, holding expected cost (based on actuarial estimates), market area, year, and the type of contract

⁶While all of the insurers report considerable success in pursuing their objective, remaining variation reflects the fact that it takes time to change local area practices that have been entrenched for years.

between Humana and the physician constant. An increase in volume from 100 to 1,000 is associated with a decline in specialty and hospital care costs per member of about 6.4 percent, holding other factors constant (see Exhibit ES.2). Further increases in volume appear to have little relationship with costs.

EXHIBIT ES.2

Specialty and Hospital Saving per Member from Volume in Excess of 100



For the market-level analysis, we sorted each insurer's IPAs into "high cost" and "low cost" groups on the basis of per member per month costs that had been adjusted for demographics and market area health care prices. For both insurers, we found that average volume was substantially greater in the low cost group than in the high cost group -- 24 to 29 percent greater for Prudential, depending on the year, and 14 to 16 percent greater for Humana.

We demonstrate the potential impact of increased volume on IPA savings by a simulation analysis that uses the provider data from Humana along with the regression results described above. If each provider in the sample with fewer than 1,000 patients were to increase his or her volume to 1,000, the regression results imply that specialty and hospital costs per patient for all the providers in the sample would drop by 2.6 percent.

While potential saving from increased IPA volume by itself is not large, increased volume is but one of a large number of ways that IPAs, as well as other forms of managed care, could increase their savings if spurred by increased price competition. We also examined several other methods that are used by the insurers to reduce costs -- capitated payments to primary care physicians, capitated payments to hospitals for specific services, and financial incentives for primary care physicians to control costs for specialty and hospital care (withholds

and bonuses) -- but our results were largely inconclusive. The inconclusive nature of these findings is indicative of the difficulties inherent in this type of research.

Chapter I

INTRODUCTION

A. Background

President Clinton's health reform proposal, the Health Security Act, as well as other major reform proposals, rely on expansion of managed care to help control the growth of health care spending. Network models of managed care -- preferred provider organizations (PPOs), point-of-service (POS) plans, independent practice associations (IPAs), and numerous hybrids -- rather than group and staff model health maintenance organizations (HMOs) are likely to dominate future expansion of managed care, just as they have dominated past expansion in recent years.

The Congressional Budget Office (CBO), which is responsible for "scoring" health care reform proposals that appear before congress, shares the prevalent view among policy makers that network forms of managed care are not capable of producing substantial cost savings. This view has increased support for other methods of controlling health spending, including global budgeting and price controls. There is, however, a widening consensus that this view is wrong -- that network models of managed care can and do produce substantially more savings than they are given credit for.

The Healthcare Leadership Council commissioned Lewin-VHI to examine readily available data from three major insurance companies -- Aetna, Humana, and Prudential -- for evidence on this issue. Our findings are presented in this report.

NETWORK MODELS OF MANAGED CARE

Individual Practice Associations (IPA): An IPA is a form of health maintenance organization (HMO) that provides health care services to enrolled members in return for a negotiated fee. The IPA contracts with physicians who continue in their existing individual or group practices, serving IPA members as well as others. The IPA pays network physicians on a per capita, fee schedule, or fee-for-service basis and may use incentives to discourage specialty and hospital care. The IPA typically requires members to use hospitals with which it has negotiated a fee schedule.

Point-of-Service Plans (POS): Under this type of plan an IPA or other HMO allows enrollees to use out-of-plan providers, but discourages use of such providers with high coinsurance rates or other methods.

Preferred Provider Organizations (PPO): Under this plan the insurer contracts with "preferred providers" and encourages members to use these providers. PPO provider rates are usually discounted, and coinsurance for use of out-of-network providers is usually high.

The estimation of cost savings from managed care is notoriously difficult. Direct comparisons of insurer costs under existing managed care plans to costs under existing fee-for-

service (FFS) plans is inadequate because of biased risk selection -- managed care enrollees are typically healthier than FFS enrollees -- and because of differences in benefits -- managed care plans typically cover more services and require fewer out-of-pocket expenditures from enrollees.

Faced with these and other problems, and given the need to limit our analysis to an examination of readily available data, we developed separate study designs for each participating insurer. The analysis for data provided by Aetna was designed to provide direct evidence on savings from managed care. The analyses for data provided by Humana and Prudential were designed to provide evidence on the potential for increased savings under health reform and the methods that insurers could use to achieve those savings. The analyses are described briefly in the next section

B. Overview

1. Managed Care Savings for Aetna Networks

Using data provided by Aetna's actuaries, we were able to compare IPA, POS, and PPO costs to FFS costs controlling for biased risk selection and benefit differences. Aetna's actuarial models were used to provide estimates of medical, administrative, and out-of-pocket costs for each type of plan for a hypothetical employer group. The estimates from the actuarial models are based on recent claims costs, administrative costs, and out-of-pocket expense experience for each product type and take into account the age/gender composition of plan enrollees, benefits, firm size and market area.

Aetna relies on its actuarial models to price its products for employer groups; thus, they have met a market test for accuracy. It is, however, likely that the models' estimates reflect historical biased risk selection that is not captured by age, gender, or other factors considered in the model. Hence, we make an additional adjustment for biased risk selection, on the basis of findings from the research literature.

Some of the savings in the resulting estimates are due to the use of utilization review (UR) by the managed care plans. Since UR can be, and often is, used in conjunction with FFS plans, we also asked the actuaries to compare the costs of FFS plans with and without UR in order to estimate the savings from UR alone.

The savings also include savings from provider discounts. Since there is controversy over whether such savings represent true social savings, rather than shifting of costs from managed care enrollees to others, we also asked Aetna to provide us with an estimate of savings that are due to discounts alone.

Aetna provided separate cost estimates for each of 26 market areas. All cost comparisons are made to plans within the same market areas and the savings estimates reported are averages over all areas. We also examine the variation in savings across market areas since this variation is relevant to the question of whether greater savings would be achieved if health reform increased the incentive to compete on the basis of price.

2. The Relationship between Costs and Volume for Humana's IPA Physicians

Managers at all three insurers told us that they could not "get the attention" of network physicians and influence their behaviors unless the physician had at least 100 patients who were IPA members. Several also suggested that the responsiveness of the physician continues to increase as the physician's volume expands, with maximum responsiveness achieved once the physician has 500 or so members. This suggests that if IPA expansion is accompanied by increasing volume, as could be expected as market penetration increases, IPA savings will increase.

To investigate this claim, we asked Humana to provide cost performance and other data on individual IPA network physicians for both 1991 and 1992. We used these data to analyze the relationship between the actual medical costs paid for a physician's IPA enrollees and the physician's volume (number of IPA enrollees), holding constant expected costs (based on gender, age, and market area), year, physician specialty, and the nature of the contract between the physician and the IPA.

3. Market Area Analysis of Humana and Prudential Networks

Both Humana and Prudential provided us with market area performance and other data for their IPAs in 1991 and 1992. In addition, Humana provided market data for its PPOs, and Prudential provided data for its POS plans. We used these data to try to determine how key features of each insurer's IPAs that were performing relatively well differed from those of their IPAs that were performing poorly; analogous comparisons were made for Humana's PPOs and Prudential's POS plans.

Performance was measured on the basis of medical costs per member after adjustments for age, gender, and market area health care costs; for Humana, an additional adjustment was made for benefit variation across markets. Plan's were sorted into "high" and "low" cost plans on the basis of this measure. For the IPAs, we compare the following features of high and low cost plans:

- volume (average enrollees per primary care physician);
- capitated payments for primary care physicians (Prudential only);
- financial incentives to control the use of specialty and hospital care (capitated payments for hospital care, bonuses, and withholds).

In addition, we compare volume across high and low cost Humana PPO market areas, and both volume and capitated payments to primary care physicians across high and low cost Prudential POS market areas.

Detailed descriptions of the methods and results for the three analyses summarized above appear in the next three chapters of the report, respectively. We summarize the main findings in the final chapter, and discuss their policy implications.

Chapter II

MANAGED CARE SAVINGS FOR AETNA NETWORKS

This chapter begins with a description of the methodology used to estimate savings for Aetna's managed care plans (Section A). We then present the findings for Aetna's "average" market area (Section B) and compare them to findings from earlier studies (Section C). Finally, we examine variation in savings across 26 Aetna market areas (Section D).

A. Methodology

1. Overview

Aetna, like other insurers, uses actuarial models to price its products. At our request, Aetna used its models to price each of its major insurance products for a hypothetical employer group. The price includes two major components -- medical costs and administrative costs (including corporate earnings) -- which are estimated separately. The models also estimate out-of-pocket expenses for deductibles, coinsurance, and copays.⁷ We estimated total costs as the sum of medical, administrative, and out-of-pocket costs. We then compared the estimated total cost for each of Aetna's managed care products (IPA, POS, and PPO) to the estimate for Aetna's traditional fee-for-service product to get an initial estimate of the savings achieved by the managed care product. To preserve confidentiality of proprietary information, we only report this estimate as a percentage of the cost for the traditional fee-for-service plan.

The initial savings estimates probably overstate the system savings from the managed care plans because of "biased risk selection". It is well established that individuals who have a choice between fee-for-service and managed care plans are more likely choose managed care if they are healthy than if they are not. This selection process by itself has the effect of making average costs for managed care plans less than for fee-for-service plans -- a difference that does not represent savings to society. While the actuarial models make some adjustment for biased risk selection, the adjustment may be incomplete. We therefore made an additional adjustment, based on a review of the literature, to remove any remaining savings that are due to biased risk selection.

⁷ Out-of-pocket expenses include only out-of-pocket expenses for services which are covered, at least in part, by the plan. Out-of-pocket expenses for other services are not included. The latter are irrelevant to the comparisons between managed care and indemnity plans; in all such comparisons both plans cover the same set of services.

A particular strength of our approach is that it allows us to control precisely for benefit differences that have confounded other research efforts. Our estimates for all plans are based on coverage for the same set of services, and take into account differences in out-of-pocket expenditures that are expected because of differences in deductibles, coinsurance, and copays. Thus, the fact that managed care plans generally cover more services (e.g., preventive care) and have lower out-of-pocket expenditure requirements than FFS plans has been fully taken into account.

In theory, percent savings under managed care may be sensitive to the specification of benefits, even if benefits are comparable under all plans. For this reason, we asked Aetna to price each product under two different sets of out-of-pocket requirements, with one set having substantially higher requirements than the other.

Aetna has actuarial models for each of its market areas. Each market area model reflects claims experience in that market area. Aetna provided actuarial estimates for each type of plan in each of the 26 market areas where it sold all of the plans in 1992. We estimated savings for each managed care product in each market area; i.e., managed care costs in each market area are compared to FFS costs in the same market area. The overall percent savings estimate reported for each managed care plan is the simple average of the estimates for the 26 markets.

Variation in savings across market areas is of interest because of its implications for potential increases in average savings under health reform. As will be seen, variation turned out to be substantial. In order to obtain some insight into why IPA savings varied across the market areas, we interviewed the regional managers who have oversight responsibility for the IPAs in those market areas that achieved the greatest and the least savings.

The savings estimates reported include savings due to both use of utilization review (UR) and discounts obtained from hospitals, physicians, laboratories and other providers. UR is commonly used by FFS plans today -- sometimes called "managed indemnity" plans. In order to estimate the UR savings included in the managed care savings estimates, we asked Aetna to also price a FFS plan with UR. Aetna also provided us with an estimate of discount savings.

The specifications for the hypothetical group and the plan benefits are presented in the next subsection. This is followed by a discussion of the adjustments made to the initial estimates for biased risk selection.

2. Group and Benefit Specifications

For each plan considered, Aetna estimated costs for a single hypothetical employer group. Aetna used the age/sex/coverage option (employee only, employee and spouse only, employee and children only, or family) distribution from its entire book of small business insurance to specify the age/sex/coverage option distribution for the hypothetical firm. The median age group in this distribution is 35 to 39, 62 percent of employees are male, and 43 percent select some form of dependent coverage. The actuaries assumed that all employees in the group would sign up for the plan, and that there were 100 employees; percent savings would be essentially the same if a larger or smaller group were used.

Each plan considered requires the patient to pay for some expenses out-of-pocket -- coinsurance, copays, and/or deductibles. Differences in out-of-pocket expenditure requirements across plan types are, to some degree, an inherent part of differences in the plans themselves. For instance, indemnity plans typically use coinsurance, PPO and POS plans use especially high coinsurance rates for out-of-network services, and IPA plans use copays that do not depend on the type or amount of care received. Hence, it is not possible to specify identical out-of-pocket expenditure provisions for all plans.

Instead, we have specified provisions that we believe to be reasonably comparable across plans. Since results could be sensitive to the provisions specified, we have specified two sets. The first set requires relatively low out-of-pocket expenditures for all plans and the second set requires relatively high ones. The requirements for both sets, hereafter referred to as the "low" and "high" out-of-pocket styles, appear in Exhibit II.1.

All of the plans within each style are identical in one respect: the three managed care plans have the same limits on out-of-pocket expenditures for in-network services as the FFS plan has for all services. Note, however that coinsurance for out-of-network services does not count towards these limits under the PPO and POS plans; instead, separate limits apply to such services.

EXHIBIT II.1

Out-of-Pocket Expenditure Specifications

Plan	Service	Out-of-Pocket Requirements	
		Low Style	High Style
IPA Plans	Physician Office Visits	\$10	\$15
	Hospital/ Institutional Care (Inpatient)	\$100 per admission	\$200 per day (max. 5 days per admission)
	Emergency Department Service (waived if admitted)	\$25	\$25
	Limit on Out-of-Pocket Expenses		
	Individual	\$1,500	\$2,000
	Family	\$3,000	\$4,000
	Prescription Drugs (includes contraceptives)	\$5/30 day supply	\$7.50/30 day supply
POS Plans	Outpatient Mental/Substance Abuse	50%	50%
	Coinsurance	none in network 30% out of network	20% in network (except inpatient at 100%) 50% out of network
	Deductible	In network hospital Inpatient \$100/admission Other in network - none Out of network - \$300 all expenses	In network hospital Inpatient \$200/day max. 5 days per admission Other in network - none Out of network - \$300 all expenses
	Other Services		
	Physician Office Visits	\$10 in network	\$15 in network
	Prescription Drugs (includes contraceptives)	\$5/30 day supply	\$7.50/30 day supply
	Outpatient Mental/Substance Abuse	50%	50%
	Limit on Out-of-Pocket Expenses		
	Individual	\$1,500 in network \$3,000 out of network	\$2,000 in network \$3,000 out of network
	Family	\$3,000 in network \$6,000 out of network	\$4,000 in network \$6,000 out of network
PPO Plans	Deductible	\$100 in network \$200 out of network	\$100 in network \$300 out of network
	Coinsurance	10% in network 30% out of network	20% in network 40% out of network
	Other Services		
	Physician Office Visits	\$10 in network	\$15 in network
	Prescription Drugs (includes contraceptives)	\$5/30 day supply	\$7.50/30 day supply
	Outpatient Mental/Substance Abuse	50%	50%
	Limit on Out-of-Pocket Expenses		
	Individual	\$1,500 in network \$3,000 out of network	\$2,000 in network \$3,000 out of network
FFS Plans	Family	\$3,000 in network \$6,000 out of network	\$4,000 in network \$6,000 out of network
	Deductibles, Coinsurance, and Copays	Physician, hospital, and emergency are same as for IPA plan	\$250 deductible 20% coinsurance (except maternity)
	Limit on Out-of-Pocket Expenses		
	Individual	\$1,500	\$2,000
	Family	\$3,000	\$4,000
	Outpatient Mental/Substance Abuse	50%	50%

All of the plans considered cover the same set of services (see Exhibit II.2).

EXHIBIT II.2
Services Covered by all Plans

Physician:	Inpatient Surgery	Anesthesia
	O/P Surgery - hospital	O/P Surgery - office
	Hospital Visits	Office Visits
	Immunizations & Injections	Therapy
	E/R Visits	Consultations
	Lab & Pathology	Well Baby
	Vision & Hearing	O/P Psych & SA
	Normal Deliveries	Deliveries with Complications
	Other Deliveries	Prescription Drug
	Contraceptives	Home Health
	Ambulance	DME
	Prosthetics	Dental
Hospital Inpatient:	Medical/Surgical/ICU	Psych
	Alcohol/Drug	SNF
	Maternity: Mother & Child	Maternity: Other
Hospital Outpatient:	Emergency	Surgery
	X-ray & Lab	Other

3. Adjustments for Biased Risk Selection

Actuarial models (including Aetna's) adjust for two factors that are associated with biased risk selection: age and gender. Since Aetna estimated costs under each plan for a single hypothetical group, with a fixed age/gender composition, the initial estimates take into account biased risk selection to the extent that it is associated with age and gender.⁸ In addition, as previously mentioned, the actuarial estimates assume that all employees in the group elect to enroll in the plan.

For these reasons we have confidence that the amount of biased risk selection reflected in the initial savings estimates is not large. This confidence is bolstered by the fact that these models have passed the market test. If the models systematically underestimate costs from managed care plans relative to fee-for-service, Aetna would typically obtain lower than expected earnings from groups with high enrollment and higher than expected earnings from

⁸A Lewin-VHI meta-analysis of previous research findings on cost savings from managed care found that differences in age/gender composition of IPA and FFS plan enrollees typically reduce IPA hospital utilization by 13 percent relative to FFS hospital utilization. See Lewin-VHI, *Effects of Managed Care, Uninsurance and AIDS on Health Care Use*, prepared for the Bureau of Health Professions of the Health Resources and Services Administration, under a subcontract from Vector Research, Inc., May 1992.

groups with low enrollment. It would then be to Aetna's advantage to adjust the models so that these systematic errors would not occur.

Nevertheless, it would be a mistake to assume that such adjustments have completely eliminated the effects of biased risk selection on the cost estimates. The effects of biased risk selection on earnings are hard to detect amidst the "noise" from the many other factors that determine actual costs. Thus, despite Aetna's considerable experience in selling these products, their models' estimates may still reflect biased risk selection.

We examined the research literature on cost savings from managed care to obtain information on how much selection bias typically remains after controlling for age and gender. While a number of studies could have addressed this question, most do not report the information needed to answer it. We did find some useful information, however, which is described further in the box below. On the basis of this information, it is our judgment that about five percentage points of the initial estimates of the difference between IPA costs and FFS costs are due to biased selection. Aetna's actuaries argue that biased risk selection is more limited in their IPA plans than in the plans analyzed in the literature, for several reasons. They specifically point to the following:

- A large number of enrollees in Aetna's plans have been enrollees for many years; while they may have been exceptionally good risks when they first enrolled, with the passage of time their risk has moved back toward the average;
- Employees planning children often enroll in HMOs in order to take advantage of generous maternity benefits. This is an important example of adverse selection for HMOs;
- In the past, one important source of biased selection has been use of mental health services; use of these services under HMO plans has been restricted by precertification, visit limits, and hospital day limits while use under traditional FFS plans has not. Similar restrictions now exist in even the most unrestricted FFS plans.
- When HMO penetration was very limited, patients were often self-selected from the extreme, low tail of the utilization distribution, making selection bias high. This is no longer true for the typical group. Instead, Aetna's enrollees often come from groups in which a very large share of workers are enrolled in managed care -- Aetna's plans as well as competitors.

The actuaries themselves estimate that the amount of savings due to biased selection is no greater than one percentage point for IPA plans. While there is substantial merit to their arguments, in the absence of more definitive empirical evidence we have elected to use the evidence from the literature review alone and deduct a full five percentage points from the IPA savings estimates produced by the actuarial models.

It is generally believed that POS and PPO plans are less susceptible to biased risk selection than IPA plans because members of these plans have a wider choice of providers (including out-of-network providers) and have more control over their use of services. Hence, we deducted three percentage points from the initial estimates of POS savings and two from the initial estimates of PPO savings.

BIASED RISK SELECTION AFTER CONTROLLING FOR AGE AND GENDER: EVIDENCE FROM THE LITERATURE

A 1992 Lewin-VHI meta-analysis of group and staff model studies compared estimates of reductions in hospital utilization across studies, taking into account differences in the ways the studies had controlled for biased risk selection. Some studies have no controls for biased risk selection, while most others control for age and gender alone.⁹ One study, the Rand Health Insurance Experiment (HIE), controlled for biased risk selection through random assignment. In general, those studies that control for age and gender alone show substantially lower savings than those which have no controls. The reduction in hospital utilization found in the HIE, however, was near the upper end of the estimates obtained in studies that only controlled for age and gender.

The recently completed evaluation of Medicare's HMO program ("TEFRA Risk Contracts") provides more direct evidence for the Medicare population.¹⁰ The evaluators controlled for biased risk selection by comparing the pre-enrollment Medicare expenditures of HMO enrollees with the expenditures of the non-enrollee group during a comparable period. Pre-enrollment expenditures were first adjusted by Medicare's Average Area Per Capita Cost (AAPCC) index, which controls for age, gender, institutional status, and welfare status. Thus, adjusted costs already control for age and gender. The evaluators found that pre-enrollee expenditures of enrollees in IPAs were 17 percent below those of the non-enrollee group. Much higher differences were found for enrollees in group and staff model HMOs, 27 and 32 percent, respectively.

These results indicate that biased risk selection is a much less important explanation of lower IPA costs than it is of lower group and staff HMO costs, once age and gender have been controlled for. At the same time, however, it suggests that differences between IPA and FFS costs due to biased risk selection could still be very high after controlling for age and gender -- as high as 17 percent. This percentage, however, substantially overstates the remaining difference due to biased risk selection because of a statistical phenomenon known as regression to the mean. Before enrollment in the IPA, the eventual enrollees had costs that were low relative to non-enrollees in large part because they were a relatively healthy group. Over time, however, the health of the IPA group would be expected to decline, on average, relative to the health of the non-enrollee group simply because some healthy people in the IPA group would become ill and some of the unhealthy people in the non-enrollee group would recover. Thus, we would have observed a significant narrowing of the difference in their expenditures had the IPA enrollees not enrolled in the IPA.

There is also a difference between the Medicare HMO market and the commercial HMO market that suggests that the difference between HMO and FFS costs due to biased risk selection after controlling for age and gender is lower in the commercial market than in the Medicare market. Medicare sets premiums on the basis of AAPCCs and Medicare expenditures for non-enrollees, on a take-it-or-leave-it basis. HMOs that routinely experience unfavorable risk selection lose money and leave the Medicare market. Those HMOs which remain in the Medicare market are most likely to be ones that routinely experience favorable selection. In the commercial market, HMOs can negotiate prices with employer groups and others, and those which routinely experience unfavorable risk selection can in many circumstances obtain reasonable compensation and remain in the market. Thus, we would expect that a smaller amount of the difference in HMO and FFS costs in the commercial market is due to biased risk selection than in the Medicare market.

⁹Lewin-VHI, May 1992, *ibid*.

¹⁰R. Brown and J. Hill, *Does Model Type Play a Role in the Extent of HMO Effectiveness in Controlling the Utilization of Services?*, Mathematica Policy Research, Inc., May 10, 1993.

B. Savings for the Average Plan

Average savings results over all market areas are reported in Exhibit II.3. Results for both benefit styles are reported. Both total cost savings and savings from the largest single component of total costs, medical costs covered by the plan, are reported. Recall that total costs include administrative costs (including corporate earnings) and out-of-pocket expenses in addition to covered medical costs.

EXHIBIT II.3
Average Managed Care Savings as a Percentage of
Traditional Fee-for-service Costs for Two Sets of Benefits^a

Managed Care Type	Low Out-of-Pocket Benefit Style		High Out-of-Pocket Benefit Style	
	Total Costs ^b	Covered Medical Costs ^c	Total Costs ^b	Covered Medical Costs ^c
Preferred Provider Organization	11%	23%	9%	19%
Point-of-Service	13%	23%	10%	22%
Independent Practice Association	23%	26%	22%	21%

^aValues reported are percent savings for managed care plan when compared to a fee-for-service plan with no utilization review, after controlling for benefits, market area, and biased risk selection. Savings include utilization review savings of approximately four percentage points and discount savings of approximately seven percentage points.

^bTotal costs include claims costs paid by the insurer, capitated payments to providers, out-of-pocket expenses for covered services, administrative costs, and corporate earnings.

^cCovered medical costs include costs for covered services that are paid by the insurer; out-of-pocket expenses for deductibles, coinsurance, and copays are not included.

The total savings estimates show real savings relative to traditional FFS plans for all three managed care plans, for both benefit styles. Savings are the greatest for the IPA; under the low out-of-pocket style, total IPA costs are estimated to be 23 percent less than traditional FFS costs; savings from POS plans are substantially lower, although still very significant (13 percent), and PPO savings are somewhat lower still (11 percent). Savings for all plans are slightly lower under the high out-of-pocket style; in comparison to the savings under the low out-of-pocket style, the greatest reduction in savings is the three percentage point reduction for POS plans.

Covered medical cost savings for all three plans are very similar. Again IPA savings are greatest, (26 percent under the low out-of-pocket style), but POS and PPO savings are only a few percentage points lower. The reason that total IPA savings are substantially greater than total POS and PPO savings is that the latter plans use high deductibles, coinsurance, and/or copays to discourage use of out-of-network services, whereas the IPA plans simply do not cover out-of-network services. Thus, while PPO and POS plans may appear to save nearly as much as IPAs in terms of premium costs, they save significantly less once out-of-pocket expenditures are taken into account. From the perspective of the enrollee, POS and PPO savings are even smaller relative to IPA savings than these numbers indicate because premiums are typically paid from pre-tax dollars and out-of-pocket expenses are not.

The savings reported in the table include savings from utilization review (UR). To estimate the savings from UR alone, Aetna's actuarial models were used to estimate the costs for the FFS plan with Aetna's standard set of UR procedures added. The result was a four percent reduction in costs.

The savings estimates also include savings from discounts that Aetna obtains from providers for its managed care products. Approximately 10 percentage points of the average savings are due to hospital discounts, and another five are due to physician discounts, for a total of 15 percentage points. These discount estimates are based on differences between what Aetna's IPA and FFS plans pay providers for identical services.

It is often argued that discount savings are not system savings because provider costs for HMO patients are "shifted" to FFS patients through higher charges; i.e., when hospitals and physicians offer discounts to HMOs, they compensate by increasing the prices they charge FFS patients. It is our view, however, that a very large share of the 15 percentage points in Aetna's discount savings represents real system savings -- 10 percentage points, if not more. Our reasons for this view are based on both economic theory and empirical evidence, as summarized below.

Economic theory indicates that a profit maximizing provider cannot shift costs to FFS customers because the profit maximizing FFS price is the same whether or not the provider is offering discounts to HMOs. The same argument applies to providers that, instead of maximizing profits, maximize net FFS revenues (gross FFS revenues minus costs for FFS patients) and use the net revenue to cover uncompensated care or to pay for other charitable objectives. Unless the provider has some motive for charging FFS customers less than the market will bear in the absence of the HMO, there is no room for cost shifting.

A better understanding of the economics of price discrimination is critical to interpreting discount savings. Profit maximizing firms charge different prices to different consumers when:

1) some consumers are less sensitive to price than others; 2) consumers who are less sensitive to price can be distinguished from those who are more sensitive; 3) consumers in one group cannot resell goods and services to consumers in the other group. Under these circumstances, a firm maximizes profits by charging a higher price to the group that is less price sensitive.

FFS and HMO patients meet these criteria; HMO patients are more sensitive to price in the sense that the HMO will send all of its patients to other providers if the provider does not agree to sell services at prices significantly below those charged to FFS patients.

The economic theory of price discrimination is discussed further in Appendix A, in the context of a health provider selling services to two types of patients: HMO and FFS. Two important implications of this theory are:

- Discount savings are real system savings. They represent the difference between excess economic profit on FFS and HMO patients and occur because HMO demand for provider services is more price sensitive than FFS demand;¹¹
- There is no reason to believe that the size of a provider's discount will change as more people switch from FFS plans to HMOs as long as the price sensitivity of HMO and FFS demand for a provider's services is unchanged.

The last point means that prices charged FFS patients will not spiral upward, through cost shifting, as more people switch to HMOs. It also means that discounts will not disappear as excess capacity in the system is removed. One factor that could reduce future discounts would be provider consolidation; HMO demand for a particular provider's services will become less price sensitive if there are fewer alternative providers in the market. This would result in increased economic profits and higher system costs.

Laws and regulations that prevent HMOs from using only selected providers would also reduce the price sensitivity of HMO demand for provider services. Comparison of the period before and after the removal of such a law in California provides the best available evidence on the importance of competition among managed care plans in reducing system costs. Until 1983, California did not allow insurers to selectively contract with providers. As has been well documented by others, removal of this law was followed by a managed care "boom" in which hospitals in market areas with the most potential competitors increased their prices at substantially lower rates than hospitals without competitors; some hospital's inflation-adjusted prices actually fell.¹²

¹¹Economic profits are profits in excess of the accounting profits necessary to keep the provider in business.

¹²Michael Morrissey summarizes the research on the California experience in *Cost Shifting in Health Care: Separating Evidence from Rhetoric*, American Enterprise Institute, forthcoming. Other research reported

Evidence on the existence of cost shifting is based on the impact of cuts in Medicare and Medicaid fees for hospital services; we have not found studies that examine cost shifting caused by HMO discounts alone.¹³ CBO has calculated the revenue needed to pay for the unreimbursed costs of hospital care provided to Medicare, Medicaid, and non-paying patients for each year from 1980 to 1989 as a share of costs for care to private payers, and compared it the private payer margin (private pay revenues in excess of private payer costs as a percentage of private payer costs).¹⁴ The comparison shows that the revenue needed for unreimbursed care increased from six percent of cost in 1980 to 15 percent of cost in 1989 while the margin increased from 13 percent to 25 percent; thus, the nine percentage point increase in revenue needed was more than matched by an increase in margin of 12 percentage points.

While this evidence is strongly suggestive of 100 percent cost shifting, there are other possible explanations. An important one is that the financial discipline imposed on hospitals by the introduction of Medicare's prospective payment system in 1983, as well as by cuts in Medicare and Medicaid rates and possibly other sources, forced hospitals to become more efficient in their operations and reduced the growth rate in hospital costs per patient. Increased efficiency reduces costs for private payer patients as well as public payer patients, but these savings need not be passed along to the private payers. Another possibility is that the hospitals which were forced to close during this period were those with the lowest private-pay margins, leaving only those with higher margins.

In order to definitively demonstrate cost shifting it is necessary to do research that examines the effects of exogenous reductions in prices for one patient group on prices paid by other payers, controlling for other factors that might also account for a relationship between these variables. A recent review of this type of research finds relatively little evidence of cost shifting.¹⁵ One study of non-profit hospitals in Illinois did find credible evidence that every one dollar reduction in hospital profits from Medicare, due to lower rates, was partially offset by a 51 cent increase in private prices; i.e., cost shifting of about 50 percent.¹⁶ Other well done studies have found less cost shifting.

on demonstrates the sensitivity of HMO demand for hospital services and the important role that selective contracting by HMOs plays in promoting price competition among providers.

¹³Momsey, *op. cit.* provides an extensive review of the theory and evidence on cost shifting.

¹⁴Congressional Budget Office, *Responses to Uncompensated Care and Public-program Controls on Spending: Do Hospitals "Cost Shift"?*, CBO Papers, May 1993.

¹⁵See Morrissey, *op cit.*

¹⁶Frank Sloan and Edward Becker found evidence of cost-shifting as high as 90 percent ("Cross Subsidies and Payment for Hospital Care," *Journal of Health Politics, Policy and Law*, vol. 8, no. 4 (Winter 1984), pp. 660-85. We put little weight on this finding because this study relies on hospital data for a

There is good reason to believe that cost shifting of HMO discounts to selected hospitals should be less than cost shifting of lower government rates to all hospitals. Hospitals may be able to cost shift lower government rates onto private payers to some degree because all hospitals are faced with the same problem and do it simultaneously; they will not lose patients to each other as a result. An individual hospital that tries to shift an HMO's discount onto its FFS patients will lose FFS patients to other hospitals that are not contracting to the HMO. Another reason to think that future cost shifting is likely to be smaller than any cost shifting in the past is that hospitals which may not have been maximizing economic rents from private payers in the past have been forced to do so due to the changes in Medicare and Medicaid policies during the last decade. At some point cost shifting is limited by the willingness of private payers to pay.¹⁷

C. Comparison to Other Research Findings

Early studies of network models of managed care generally found very limited savings, especially in comparison to savings found for group and staff model HMOs. These studies, however, were conducted during the infancy of network models when insurers did not have much experience in managing care in the network environment, physicians were resistant to joining networks and being managed, and it was rare to have more than two or three networks competing in a market area. A number of more recent studies have found savings for IPAs that are much more in line with our own. Evidence on POS and PPO plans remains scanty, especially in the case of the former.

Most studies analyze various measures of inpatient and outpatient utilization, rather than costs. One reason for this is that accurate and complete cost data are often not available. Percentage savings are often assumed to be proportional to utilization savings, on the assumption that medical and administrative expenditures are proportional to utilization. When savings are calculated in this way, they ignore the discount savings that account for a substantial share of HMO savings. Since discount savings for Aetna's IPAs are, on average, about 15 percent of FFS costs, our finding that Aetna's IPAs realize average savings of 23 percent translates into average utilization savings of roughly eight percent.

single period, rather than on changes over time. The main problem with using data from a single period is that it is not possible to adequately control for many factors which vary across hospitals.

¹⁷See Allen Dobson and James Roney, *Cost-shifting: A Self Limiting Process*, Lewin-ICF, April 1992.

1. Early Research

In a 1992 Lewin-VHI summary of earlier research on costs savings from managed care, we examined 14 IPA studies and concluded that the typical IPA study found no reduction in hospital utilization relative to FFS plans after controlling for age and gender, and an increase in outpatient visits.¹⁸ If these results are accurate, then IPA costs could not have been lower than FFS costs unless there were savings from lower administrative costs or discounts.

One study that has had a significant influence on the scoring of managed care savings by CBO and others is a Lewin-VHI analysis of the 1989 National Health Interview Survey data. This study compares hospital utilization and outpatient visits for enrollees in FFS plans, Group HMOs, and IPA HMOs, using regression analysis to control for age, gender, and health status, as well as family income, geographic area, and urban/rural status. The study finds that group model HMOs reduce hospital utilization by 19 percent, while IPA models reduce hospital utilization by only seven percent. Both HMO models are found to increase outpatient visits -- by seven percent for Group HMOs and 10 percent for IPAs.

The CBO used the results from the NHIS analysis in support of its assumption that new enrollment in HMOs (IPA and Group combined) will reduce use of services by 7.5 percent.¹⁹ CBO weights inpatient and outpatient utilization reductions by the share of inpatient and outpatient costs in total costs, and conclude that Group HMOs reduce total utilization by nine percent while the reduction for IPAs is less than 0.5 percent.

In summary, early studies did not find any credible evidence of utilization reductions for IPAs at all, let alone the 8 percent reduction that would be roughly consistent with our findings of 23 percent savings for Aetna's IPAs.

2. Recent IPA Studies

In November of 1993, the American Managed Care and Review Association (AMCRA) released a review of recent studies of managed care savings that focused on savings from network models of managed care. On the basis of this review, the study concludes that "there is no evidence that HMO savings differ substantially by model type [i.e., IPA savings are just as great as Group or Staff HMO savings]. The present review concludes that, on average, HMOs achieve savings of 27.1% beyond traditional fee-for-service plans. This average savings rate is based on component savings ranging from decreases in hospital admissions of 34% and

¹⁸Lewin-VHI, May 1992, *ibid*.

¹⁹CBOs position is presented in an attachment to a November 10, 1993 memorandum from Robert Reischauer to Representative Michael A. Andrews.

hospital length of stay of 16%, to increases in ambulatory primary care physician utilization of 3.3%."²⁰

While the conclusion that HMOs achieve average savings of 27 percent is very consistent with our finding of 23 percent savings for Aetna's average IPA, we have some reservations about whether the research reviewed warrants this conclusion. In particular, it is not at all clear that the 34 percent reduction in hospital admissions found in one study can be generalized to other HMOs.²¹ IPA, Staff, and Group HMOs are not clearly distinguished in the study, but a grouping of HMOs that roughly corresponds to these models show that Staff and IPA models reduce admissions by only 29 percent, in comparison to 39 percent for group models. In fact, one other study discussed in the report finds no significant reduction in admissions.

While we have reservations about the report's conclusion on the magnitude of reductions in hospital admissions, the conclusion of 16 percent reduction in hospital length-of-stay (LOS) appears to be on solid ground. Five recent studies examined IPAs and their estimates of LOS reductions range from 10 percent to 38 percent. While all of the studies reported have flaws, all do a reasonable job of controlling for biased selection and other factors. The greatest single shortcoming of these studies is that they examine either special populations or admissions for only a few diagnoses; hence, the generality of the results is unclear.

Despite our reservations about the conclusions of the AMCR report, the findings of the IPA studies reported on are clearly stronger than findings from earlier studies and more consistent with the findings for Aetna IPAs.

3. POS and PPO Studies

The AMCR report also reviews existing POS and PPO studies. Only one POS study is cited.²² While the 13 percent savings found in this study is identical to the average savings found for Aetna's POS plans, this may simply be coincidental. As the AMCR report points out, there are methodological problems with the POS study and the fact that it is based on a single employer group makes generalization very risky.

²⁰Robert Giffin, Managed Care Cost Containment: A Review and Reassessment, Health Care Strategy Associates, Inc., November 1, 1993, p. iv.

²¹N. Greenfield, E. Nelson, M. Zubkoff, W. Manning, W. Rogers, R. Kravitz, A. Tarlov, and J. Ware, "Variations in Resource Utilization Among Medical Specialties and Systems of Care: Results from the Medical Outcomes Study," *Journal of the American Medical Association*, vol. 267, no. 12, March 25, 1992, pp. 1624 - 30.

²²R. Goetzel, K. Thorpe, J. Fielding, and K. Pelletier, "Behind the Scenes of a POS Program," *Journal of Health Care Benefits*, March/April, 1992, pp. 33 - 37.

The AMCR report reviews four PPO studies. Findings range from substantial savings to higher costs. The methodologically strongest study, based on the Rand PPO Project, found a reduction in charges of 25 percent.²³ This is in line with our finding of a 23 percent reduction in average medical costs for Aetna's PPOs, but is substantially greater than our finding of 11 percent savings once administrative and out-of-pocket costs are included.

D. Variation in Savings Across Markets

The savings reported in Section B are averages over the 26 market areas for which we obtained savings estimates from Aetna. The averages hide high variation in savings across market areas. This variation is shown in Exhibit II.4, where we report our point estimates of savings in the markets with the greatest and least savings. The estimates for each plan have been adjusted by our point estimate for the effect of biased risk selection.

EXHIBIT II.4
Range of Managed Care Savings as a Percentage of
Traditional Fee-For-Service Costs Across 26 Market Areas^a

Managed Care Type	Low Out-of-Pocket Benefit Style		High Out-of-Pocket Benefit Style	
	Total Costs^b	Covered Medical Costs^c	Total Costs^b	Covered Medical Costs^c
Preferred Provider Organization	-1 to 20%	11 to 32%	-3 to 18%	7 to 28%
Point-of-Service	1 to 25%	10 to 34%	-2 to 22%	9 to 33%
Independent Practice Association	11 to 34%	15 to 37%	9 to 33%	10 to 34%

^aValues reported are the range, across 26 market areas, of percent savings for managed care plan when compared to a fee-for-service plan with no utilization review, after controlling for benefits, and biased risk selection. Savings include utilization review savings of approximately four percentage points and discount savings, which vary across market area.

^bTotal costs include claims costs paid by the insurer, capitated payments to providers, out-of-pocket expenses for covered services, administrative costs, and corporate earnings.

^cCovered medical costs include costs for covered services that are paid by the insurer; out-of-pocket expenses for deductibles, coinsurance, and copays are not included.

²³S. Hosek, M. Marquis, and K. Wells, *Health Care Utilization in Employer Plans with Preferred Provider Organization Options*, Rand, February 1990.

The range of savings is very wide for each type of plan -- from 21 to 24 percentage points, regardless of benefit style. The IPA with maximum saving saved over three times as much as the IPA with minimum saving (34 percent vs. 11 percent). The point estimates suggests that the PPO and POS plans in some market areas may actually have cost a little bit more than the traditional FFS plans, but in other market areas savings were as high as 25 percent for POS plans and 20 percent for PPO plans.

The most significant explanation of variation in savings is variation in provider discounts for managed care enrollees that are not extended to FFS patients. When savings were re-estimated using a common discount factor for all areas, the difference between IPA savings in the areas with the highest and lowest savings was reduced from 23 percentage points to just four percentage points. This explanation of savings variation is, however, only a proximate one; it begs the question of why discounts vary so significantly from one market area to the next.

In order to obtain insight into the reasons for discount variation as well as other explanations of savings variation, we interviewed the regional managers who were responsible for the IPAs in the market areas that apparently achieved the greatest and least savings. The three areas with the highest savings and the two areas with the lowest savings were examined. While the three high savings areas were among those with the highest discounts, they also had the highest savings after deducting discount savings; similarly, discounts in the two low savings areas were among the lowest, and these areas still had the lowest savings after deducting discount savings.

According to the regional managers, the three high savings areas were all characterized by high HMO penetration and widespread acceptance of managed care among both providers and patients. The managers attributed the high savings in these areas at least in part to intense competition among the HMOs. In contrast, one of the low savings areas was described as an "immature" managed care market, with little acceptance of HMOs among both providers and patients. The other low savings area had moderate HMO penetration, and its low savings were largely attributed to another factor (see below.) Thus, market maturity and intensity of competition among HMOs appears to be an important determinant of HMO savings.

Other features that, according to the regional managers, made a difference are described below.

- The total number of IPA enrollees and the number of enrollees per primary care physician (volume) were both important. The larger the number of enrollees, the more success Aetna has in its negotiations with hospitals and other providers. The

more enrollees that a physician has, the more likely will the physician pay attention to Aetna's suggestions and incentives to improve performance.

- Financial incentives for primary care providers played an important role. Payments for primary care were capitated in all of the high savings areas and were especially important in controlling costs. One of the two low savings areas did not capitate primary care. The managers also mentioned the importance of withholds and bonuses, but all five of the areas had incentive programs and we could not determine whether some were stronger than others.
- An insurer's ability to influence performance may be limited by the structure and ownership of the IPA, and one low saving area provided an example. In this area, Aetna's IPA physicians consisted of all physicians in a single large clinic. While Aetna owned a share of the clinic, it was not the majority owner. The clinic reviewed its own utilization and performance with respect to all patients. Hence, Aetna had only limited opportunity to have a direct impact on the clinic's practice. Aetna eventually discontinued this IPA, for this reason.

These observations are reasons to believe that health reform incentives to encourage both enrollment in managed care and price competition among managed care providers will result in greater savings than observed currently. Growth and competition would likely be fostered by: larger IPA networks, that would have more power to negotiate with providers; greater acceptance of managed care by both providers and patients; larger IPA enrollment per network primary care physician, that would make it easier for insurers to influence the physicians' behavior; and stronger incentives to control costs through whatever management methods are available to the insurer, including financial incentives for primary care physicians. These observations may also help explain why the most recent studies of IPA savings are finding significant savings, whereas earlier studies did not.

In the next two chapters we present further evidence on factors that may determine the extent of IPA savings.

Chapter III

THE RELATIONSHIP BETWEEN COSTS AND VOLUME FOR HUMANA'S IPA PHYSICIANS

Humana provided performance and other data for each of its IPA primary care physicians in 1991 and 1992. We used these data to analyze the relationship between the actual medical costs paid for a physician's IPA enrollees, exclusive of the capitation payment made to the physician for primary care, and the physician's volume (number of IPA enrollees), holding constant expected costs (based on gender, age, and market area), year, physician specialty, and the nature of the contract between the physician and the IPA. The costs included are primarily for specialty and hospital care, but also include costs for drugs, medical equipment, and laboratory work. We used the results of this analysis to simulate the cost effect of increasing the volume of each IPA physician with fewer than 1,000 enrollees to 1,000.

A brief description of the data and methodology appear in Section A; further details are in Appendix B. The results are presented in Section B, and the simulation is discussed in Section C.

A. Data and Methodology

We used 1991 data for 815 Humana primary care physicians and 1992 data for an additional 863. The variables used in our analysis are listed in Exhibit III.1. The most central to the analysis are *Cost*, which is primarily the cost of specialty and hospital care for the physician's IPA members, *Expected Cost*, which is the amount Humana set-aside in "funds" from which to pay these costs on the basis of actuarial estimates, and *Volume*, which is simply the number of IPA enrollees who have chosen the physician as their primary care provider. Other variables, which indicate market area (*Market*), the nature of the contract between Humana and the physician (*Contract*), and the year (*Year*) were used as "control" variables.

EXHIBIT III.1

Variable Definitions

Variable	Definition
<i>Cost</i>	The medical costs of the physician's IPA enrollees during the year exclusive of the capitated payment made to the physician for primary care, divided by the number of enrollees. The bulk of these costs are for hospital and specialty care.
<i>Expected Cost</i>	The sum of all funds that were set aside by Humana for payment of the physician's enrollees' costs (not including primary care capitation payments), divided by the number of enrollees. These funds are based on Humana's experience in the market area for enrollees with the same age/gender composition as the physician's enrollees.
<i>Volume</i>	The number of IPA enrollees who designated the physician as their primary care provider during the average month of the year.
<i>Market</i>	A set of 17 "dummy" variables to indicate in which of Humana's 17 market areas the physician is located.
<i>Contract</i>	A set of 22 dummy variables to indicate the type of contract that Humana has with the physician. In a typical market, several contract types are used. While one is usually the dominant type, for a variety of reasons a substantial number of physicians may have some other type. The main difference between two types of contracts is usually related to incentives and risk sharing.
<i>Year</i>	A dummy variable to indicate which year the data are for, 1991 or 1992.

Multiple regression analysis was used to analyze the relationship between the *Cost* and *Volume*. The *Expected Cost*, *Market*, *Contract*, and *Year* variables were used to control for the effects of these factors on cost. The hypothesis is that there is a negative relationship between *Cost* and *Volume*, holding the other factors constant.

As described in the appendix, we experimented with the mathematical form of the relationship between *Cost* and *Volume*. The insurers suggested that the strength of the relationship between the two variables would diminish as *Volume* increased; i.e., a given increase in *Volume* would have a smaller effect on *Cost* for a physician whose *Volume* was already high than on *Cost* for a physician with low *Volume*. We found that a particular form which has this feature fit the data well. The form specifies that a given percent increase in *Volume* has the same effect on *Cost* no matter how high *Volume* is initially.

B. Results

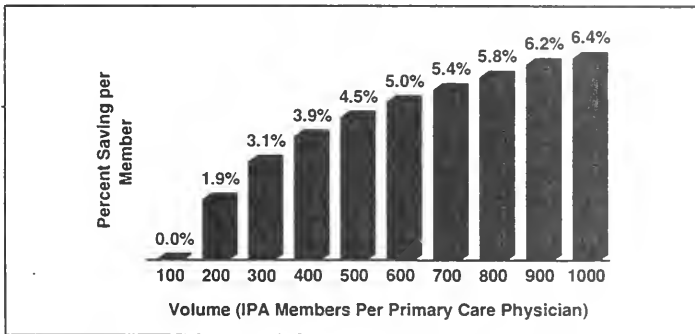
Our estimates show that a one percent increase in volume is associated with a reduction in cost per IPA enrollee of .028 percent, holding expected cost and other things constant (e.g.,

an increase in *Volume* from 100 to 101 is estimated to reduce *Cost* by .028 percentage points). This result is statistically significant at the .01 level.²⁴

The small effect of a one percent change in *Volume* represents a substantial effect when comparing physicians across the wide range of *Volume* that is observed in the sample. The relationship is illustrated graphically in Exhibit III.2, where we report estimated percentage saving per enrollee obtained by increasing *Volume* from 100 to values from 200 to 1,000, holding expected cost per enrollee and other factors constant. An increase in *Volume* from 100 to 500 is of particular interest because this is the range of *Volume* that was suggested to be critical by the insurers. This change is well within the range of changes observed from 1991 to 1992 for physicians who were in the Humana sample in both years; changes of this magnitude occur as Humana adds major new employer groups to the groups it already serves.

EXHIBIT III.2

Hospital and Specialty Saving per Member from Volume in Excess of 100



*Based on regression estimates. Expected cost per enrollee, provider specialty, market area, contract type, and year are held constant.

On the basis of our results, we estimate that an increase in *Volume* from 100 to 500 reduces cost per patient by 4.5 percent. The estimates also show additional savings as *Volume* increases beyond 500. An additional increase in *Volume* by 400 enrollees, to 900 enrollees, reduces costs by only an additional 1.9 percentage points -- a much smaller change, as anticipated by the insurers, but still significant.

²⁴This means that the chance of finding a result as strong as the one we found if, in fact, there is no relationship between *Cost* and *Volume* is only one percent.

In the discussion above we interpret the estimated relationship between the *Cost* and *Volume* as a causal one; i.e., increasing the physician's enrollees causes a reduction in costs per enrollee, other things constant. The regression evidence *per se* does not imply this interpretation. Although the findings are consistent with the hypothesis of a causal link, there could be other explanations. One possible explanation is that the volume of IPA enrollees is strongly correlated with total patient volume, and high volume physicians typically have lower costs per patient. It might also be that IPA volume is related to physician age, with younger physician's relying more heavily on IPAs to obtain patients. If so, the estimated relationship could partially reflect greater willingness on the part of relatively new physicians to adopt the cost effective practice patterns that are promoted by IPAs.

We do not have the data that we would need to disentangle these possible cost-volume relationships from the causal one we are trying to estimate. We have discussed these issues with management at Humana, and they believe that, for their IPA physicians, the correlations between IPA patient volume, total patient volume, age, and gender are low.

C. Simulation of the Effect of Expanding Volume

Since the strength of the relationship between *Cost* and *Volume* diminishes as *Volume* increases, the potential for savings from increasing *Volume* depends on the actual distribution of *Volume* among physicians who are IPA members. To get a clearer indication of how large the potential savings are, we used the regression results and the Humana provider sample to simulate the effect of increasing *Volume* to 1,000 for all providers with initial *Volume* of less than 1,000.²⁵

We estimate that increasing *Volume* to 1,000 for all providers with *Volume* less than 1,000 would reduce hospital and specialty cost per enrollee by about 2.6 percent of actual cost per enrollee. Thus, given the distribution of *Volume* for Humana's IPA physicians, there appears to be substantial potential for reducing costs by increasing volume. Of course, the *caveats* made with respect to the regression results at the end of the previous section apply to these results as well. In addition, the effect of expanding *Volume* could very much depend on

²⁵To be more specific, we used the regression estimated from the full set of observations for 1992 to estimate the reduction in cost per enrollee for each PCP with *Volume* of less than 1,000 from increasing the physician's actual enrollment to 1,000, holding Humana's expected cost per enrollee and other factors constant. We then used the physician's predicted cost per enrollee along with actual cost per enrollee for physicians whose actual *Volume* was at least 1,000 to compute cost per enrollee for all sample physicians combined. In computing the latter, we used each physician's original enrollment to weight the physician's cost per enrollee; thus, the result is an estimate of the cost per enrollee for the actual enrollees had the hypothetical additional enrollees actually been present. Our estimate of the savings per enrollee is the difference between this estimate and the actual cost per enrollee for the same set of enrollees.

how *Volume* is expanded, and both *Volume* distributions and the relationship between *Volume* and *Costs* could be substantially different for other insurers.

Chapter IV

MARKET AREA ANALYSIS OF HUMANA AND PRUDENTIAL NETWORKS

In this chapter we present our analysis of market area data for Humana and Prudential. Both insurers provided us with market area performance data for their IPAs; in addition, Humana provided data for its PPOs and Prudential provided data for its POS plans.

For each plan type and each insurer we divided the market areas into high and low cost groups on the basis of costs per member after adjusting costs for market area prices and member demographics. We then compared the features of the plans in the high cost areas to those of the plans in the low cost areas in order to determine whether there was a systematic relationship between any feature and costs per member. The features examined are:

- volume (members per primary care physician);
- use of capitation payments for primary care; and
- financial incentives to control hospital and specialty care costs.

The data are described in Section A, the methodology is discussed in Section B, and the results are presented in Section C.

A. Description of the Data

1. Humana Markets

Humana provided IPA data for 17 market areas in both 1991 and 1992; PPO data were provided for 15 market areas in 1991 and 16 in 1992. Data for both products include: medical cost "per member per month" (PMPM); hospital cost PMPM; an actuarial factor for age/gender and industry of employment for the plan's members; an actuarial factor for benefit design; the number of members; and the number of primary care physicians (PCPs) in the network.

Humana also provided information about the financial incentives given to PCPs in its IPAs to control specialty and hospital costs. Financial incentives are complex, and vary from market to market; in fact, there is usually some variation within market areas. For our analysis, however, we needed to characterize differences across markets in a very simple, yet meaningful, way. We derived a scheme for dividing market areas into two groups. In one group, PCPs accept 100 percent of the risk of "excess" hospital and specialty care costs, up to a limit, and in the other they accept only 50 percent of the risk, again up to a limit.

MEASUREMENT OF PCP RISK SHARING FOR HOSPITAL AND SPECIALTY COSTS

The classification of Humana's markets into "50 percent risk-sharing" or "100 percent risk-sharing" for hospital and specialty costs is based on a review of two risk-sharing mechanisms that Humana uses in order to control hospital and specialty costs: withholds and bonuses. For withholds, insurers withhold a share of capitated payments until the end of an accounting period, at which time costs for hospital and specialty care above some designated ("funded") amount are paid, at least in part, from the withheld capitated payments, and the PCP receives whatever is left. Bonuses are paid to PCPs on the basis of fund surpluses which arise when the costs of specialty and hospital care fall below funded amounts; in this case the PCP receives a share of the surplus, up to some limit.

Thus, withholds are used by insurers to share "downside" risk with PCPs, and bonuses are used to share "upside" risk. To a large extent, however, the distinction between downside and upside risks is illusory. To see why, consider a contract with a withhold and a given level of sharing of downside risk, but no sharing of upside risk. This contract can be converted into a contract that has the same financial implications for both the PCP and the insurer by: eliminating the withhold; reducing the capitated payment by the amount of the former withhold; increasing funding for hospital and specialty care by the amount of the former withhold; and paying a bonus for keeping costs under the funded amount, with a maximum equal to the former withhold. While the former contract "penalizes" the PCP for high specialty and hospital costs and the latter "rewards" the PCP for low costs, offsetting changes in the primary care capitated payment and the amount of funding for specialty and hospital care make them financially equivalent.

Given the illusory nature of the distinction between withholds and surpluses, it becomes apparent that the most important feature of these incentives is the PCPs share of the risk: the share of each dollar of surplus given to the PCP and/or the share of the excess cost for which the PCP is liable. We classified all market areas into two groups on the basis of the risk-share for bonuses under the predominant contract in that market; in all cases this was either 50 percent or 100 percent. We chose to neglect the risk-share for withholds because Humana has been phasing out withholds and placing greater emphasis on bonuses; only 5 of the 17 market areas had withholds in 1991 and 1992, while all had bonus plans. In four of these five markets, the risk-share for withholds was the same as for bonuses; in the fifth, the risk-share for withholds was larger than for bonuses (100 percent vs. 50 percent) and our classification scheme may understate the extent to which PCPs in that market area are at risk. Reclassifying that area did not, however, have a substantive effect on the result. A separate withhold variable was also constructed, but analysis of this variable yielded no meaningful results.

2. Prudential Markets

Prudential provided IPA data for 26 market areas in both 1991 and 1992; POS data were provided for 34 markets in both years. Data for both products include: medical cost per member (enrollee) per month (PMPM); hospital cost PMPM month; hospital days per thousand members; an actuarial factor for the age/gender composition of the plan's members; the number of members; and the number of primary care physicians (PCPs) in the network.

Prudential also provided information about features of its contracts with physicians in each market area. We used this information to create three financial variables to capture contract features which vary across market area. First, we classified a market area as having "primary capitation" if the dominant contract used in the market area included capitated payments to PCPs; otherwise the area was characterized as fee-for-service. Second, for IPAs only, we classified each area as either "hospital capitation" or not, depending on whether

hospitals received capitation payments for IPA members to cover a specified set of hospital services. Third, we classified each area as either "bonus/withhold" or not if financial incentives (withholds and/or bonuses) were given to PCPs to control specialty and hospital care costs.

B. Methodology

First, for each network type, each insurer, and each year we divided networks into "high cost" and "low cost" groups. Classification was based on costs PMPM after adjusting them for: age, gender and, for Humana, industry; benefit design (Humana only); and a market area medical price index.

There are very large differences in costs between the high and low cost market areas for each insurer and each network type, as shown in Exhibit IV.1 where we report the percent differences in cost PMPM between the high and low cost market areas. While inadequacies in the adjustments for demographics, market area medical prices, and other factors may have resulted in misclassification of some markets, the large differences in costs between the two groups gives us reasonable confidence that the average high cost market area has substantially higher costs than the average low cost market area in each high/low cost pair.

EXHIBIT IV.1
Percent Difference in Medical Cost PMPM and Hospital
Cost PMPM between High and Low Cost Markets^a

	Percent Difference	
	1991	1992
Humana IPAs	17 market areas ^b	
Medical Cost PMPM	32%	32%
Hospital Cost PMPM	33%	46%
Prudential IPAs	26 market areas	
Medical Cost PMPM	40%	39%
Hospital Cost PMPM	44%	45%
Prudential POS Plans	34 market areas	
Medical Cost PMPM	25%	28%
Hospital Cost PMPM	29%	33%
Humana PPOs	13 market areas ^c	
Medical Cost PMPM	29%	46%
Hospital Cost PMPM	43%	46%

^aThe values reported compare the average costs in half of the market areas indicated with the highest medical costs PMPM to the average in the half with the lowest costs. The base for each percentage is average cost in the low cost areas.

^bThe high cost group includes eight markets and the low cost group includes seven.

^cThe high cost group includes six markets and the low cost group includes seven. Three south Florida market areas were aggregated into a single market area for this analysis due to lack of information on PCPs for each area separately.

Percent differences in hospital costs PMPM, adjusted by the same methodology as for all medical costs, are also shown in the exhibit. In every case these are at least as large as the percent differences in all medical costs PMPM. This suggests that factors which affect hospital costs should be of special significance in differentiating high and low cost market areas, although factors that affect other components of medical costs should also be important.

Next we compare key features of the market areas in the high and low cost groups for each insurer, network type, and year. Each feature is measured by a specific variable (e.g., "volume" or members per PCP). For continuous variables (e.g., volume) we report the difference in the average of the variable; for categorical variables (e.g., for capitation) we report the difference in percent.

This analysis provides a characterization of high and low cost market areas in terms of features that are hypothesized to have an impact on cost. For some categorical variables we follow up this analysis with a comparison of costs for market areas with and without the relevant feature.

It should be noted that findings for Humana's IPA and PPO plans are not entirely independent of each other because most physicians in Humana's IPA networks are in a Humana PPO network as well; results for Prudential's IPA and POS plans are related for an analogous reason. Further, results for 1991 and 1992 are not entirely independent because there are only limited changes in market features and groupings from one year to the next.

C. Results

The results of this analysis are largely inconclusive. For the most part, the results for volume are consistent with the hypothesis that increases in volume reduce costs. Results for capitated payments for primary care and for financial incentives to control specialty and hospital costs are sometimes consistent with hypothesized effects, but are counter to expectations almost as often. Details of the findings are discussed below.

It would be a mistake to view the mixed results as evidence against the usefulness of capitated payments for primary care and financial incentives to control specialty and hospital costs. Instead, the inconclusive results reflect the very large variation in costs that we found across market areas and the difficulties of identifying the effects of what may only be a small subset of the factors which explain that variation. It would also be a mistake to attribute the results for volume to the effects of volume alone since the data are not rich enough to let us separate the effects of volume from many confounding factors.

1. Volume

Percent differences in volume between high and low cost market areas are reported by network type, insurer, and year in Exhibit IV.2. With the exception of the results for Prudential's POS plans, these results provide further evidence that is consistent with the view that increases in volume reduce cost.

EXHIBIT IV.2

Percent Difference in Volume between High and Low Cost Markets^a

	Percent Difference	
	1991	1992
IPAs		
Humana	16%	14%
Prudential	29%	24%
POS Plans		
Prudential	-19%	-19%
PPOs		
Humana	59%	22%

^aVolume is measured as number of enrollees per PCP. Average volume in the low cost market area is the base.

If cost differences for the IPA markets are entirely due to volume differences, then a simple estimate of the impact of volume on savings would be the ratio of the percent difference in cost PMPM to the percent difference in volume. For each of the IPA comparisons, this ratio exceeds one, suggesting that a one percent increase in volume results in a greater than one percent reduction in costs. This is a much larger effect of volume on costs than was obtained from the provider-level analysis for Humana, where we found that a one percent increase in volume was associated with only a .03 percent reduction in cost per enrollee. The finding from the cross-market comparisons is too large to be credible as an effect of volume on IPA costs alone. Differences in volume no doubt reflect differences in cost-factors that we have not been able to control for, including those discussed in the next two subsections.

2. Capitated Payments for Primary Care

Evidence on the effect of capitated payments comes from Prudential's IPA and POS plans only; capitation is the dominant method of payment in all of Humana's IPA networks, and

capitated payments are not used in PPOs due to the nature of PPO networks.²⁶ In both 1991 and 1992, 77 percent of Prudential's low cost IPA networks used capitated payments while only 54 percent of its high cost IPA networks did, a 23 percentage point difference. While this finding is consistent with the hypothesis that use of capitated payments is important for IPA networks, we do not obtain the same results for Prudential's POS plans; 29 percent of POS market areas use capitated payments in both the high and low cost groups.

Another way to look at the Prudential data with respect to capitated payments for primary care is to group markets by whether or not capitated payments are used and to compare costs in the capitated and non-capitated groups. When we did this, we again found mixed results: IPA market areas with capitated payments had medical costs PMPM that were 12 percent lower in 1991 than market areas without capitated payments, but in 1992 the difference was only two percent. For POS plans, medical costs were actually higher in the areas with capitated payments than in those without -- by eight percent in both 1991 and 1992. A somewhat perplexing finding is that hospital costs PMPM are consistently, and substantially lower in the market areas with capitated primary care payments.²⁷

3. Financial Incentives for Primary Care Physicians to Control Hospital and Specialty Care Costs

Differences in the percent of high and low cost market areas using various methods to control specialty and hospital care costs are reported in Exhibit IV.3. The results are very mixed and inconclusive. Differences are generally small, and often the feature is more prevalent in the high cost market than in the low cost market.

²⁶Capitated payments cannot be made to PCPs in PPOs because enrollees are not assigned to individual PCPs.

²⁷For the IPA markets, hospital costs PMPM in markets with capitated PCP payments were 22 percent lower in 1991 and six percent lower in 1992; for the POS markets the differences were 17 percent and 16 percent for the two years, respectively.

EXHIBIT IV.3

**Difference in Percent of High and Low Cost Market Areas Using
Various Financial Incentives to Control Specialty and Hospital Costs^a**

	Difference in Percent	
	1991	1992
Humana IPAs 100% risk-sharing ^b	19%	-2%
Prudential Hospital Capitation ^c IPAs	-7%	8%
Bonuses/Withholds ^d IPAs	-23%	-23%
POS plans	-11%	6%

^aValues reported are percent of markets in low cost group with feature minus corresponding percent of markets in high cost group.

^bPercent of markets in which PCPs are paid 100 percent of surplus funds, up to a maximum; in all other markets PCPs are paid 50 percent.

^cPercent of markets in which capitated payments are made to hospitals for a specified set of services.

^dPercent of markets in which withholds and/or bonuses for PCPs are used to control hospital and specialty care costs.

It could be that the effects of the various incentives are being masked by other factors that contribute to cost differences between the high and low cost markets, including volume and PCP capitated payments. This is especially true for the analysis of Humana's risk-sharing arrangements because 82 percent of all market areas had 100 percent risk-sharing; inevitably a large share of markets in both the high and low cost groups had to have 100 percent risk-sharing, so the impact of risk-sharing on the difference in average costs cannot be very large. Analogous problems arise in the comparison of hospital surplus payments for Prudential's POS plans; only 24 percent used hospital surplus payments each year.

To examine this possibility further, we reclassified markets into those with and without the incentive of interest. Results are reported in Exhibit IV.4. When the data are looked at in this way, the Humana data show stronger evidence of savings from the 100% risk-sharing, but the Prudential results for hospital capitation and bonuses/withholds remain mixed. Especially troublesome is the finding that hospital costs in the market areas with bonuses/withholds are consistently, and substantially, higher than in areas without them.

EXHIBIT IV.4

**Percent Difference in Cost between Markets
With and Without Various Incentives^a**

	Percent Difference	
	1991	1992
Humana IPAs		
100% risk-sharing ^b		
Medical Cost PMPM	-17%	-14%
Hospital Cost PMPM	-16%	-10%
Prudential		
Hospital Capitation ^c		
IPAs		
Medical Cost PMPM	-1%	-5%
Hospital Cost PMPM	-4%	1%
Bonuses/withholds ^d		
IPAs		
Medical Cost PMPM	9%	6%
Hospital Cost PMPM	14%	9%
POS plans		
Medical Cost PMPM	5%	9%
Hospital Cost PMPM	20%	29%

^aValues reported are percent difference between costs in markets with and without the specified incentive. The base group is the market without the incentive; negative values indicate the market with the incentive has lower costs.

^bThe number of markets with 100 percent risk-sharing is 14; the other three have 50 percent risk-sharing.

^cThe numbers of IPA markets with and without hospital capitation in 1991 were 9 and 17, respectively; in 1992 the respective numbers were 15 and 12.

^dThe numbers of IPA markets with and without bonuses/withholds in 1991 were 9 and 17, respectively; in 1992 the respective numbers were 10 and 17. For POS markets the respective numbers are 8 and 27 for 1991 and 7 and 28 for 1992.

Chapter V

SUMMARY AND CONCLUSION

This chapter begins with a brief summary of our findings (Section A). We then discuss the implications of the findings for health care reform (Section B). We conclude with a brief discussion of the effects of managed care on the long term growth rate of health care costs (Section C).

A. Summary

Our main findings are summarized below.

1. Managed Care Savings for Aetna Networks

We estimate that savings from Aetna's average IPA plan are about 23 percent of the costs of a traditional fee-for-service plan in the same market area, after accounting for administrative and out-of-pocket costs as well as biased risk selection and covered services. Utilization review savings of four percentage points are included in these savings; these could, and often are, obtained under Aetna's "managed" fee-for-service plans. Discount savings of approximately fifteen percentage points are also included, of which at least 10 percentage points represent, in our judgment, system savings. Thus, we estimate system savings of 14 percent relative to managed FFS.

The two other types of network managed care we examined also generate significant savings. Average savings from Aetna's point-of-service plan are estimated to be 13 percent of the costs of a traditional fee-for-service plan, and average savings from Aetna's preferred provider organization plan are estimated to be 11 percent. As with the IPA savings estimates, these estimates include utilization review and discount savings.

We also found substantial variation in savings for each network type across the 26 market areas. IPA savings as high as 34 percent were found in some areas and as low as 11 percent in others; the range for POS savings was from one to 25 percent, and that for PPO savings was from minus one percent (i.e., it was more costly) to 20 percent. Discounts were the proximate cause of a large share of this variation. We discussed explanations of discount variation and other sources of savings with the Aetna regional managers responsible for the

three market areas that showed the greatest savings and the two areas that showed the least. It is their view that the following factors are important sources of savings variation:

- *Competition.* Savings are greatest in markets where managed care penetration is high and competition among managed care insurers is intense. Managed care enjoys wide acceptance by both providers and individuals in these areas, and this makes it easier to improve performance.
- *Market penetration.* Networks that are large relative to their market areas have more success in negotiations with hospitals and other providers.
- *Volume (enrollees per primary care physician).* IPA primary care physicians who have more IPA patients pay more attention to Aetna's performance improvement efforts than do those who have fewer.
- *Capitated payments for primary care physicians.* IPA primary care physicians who are paid on the basis of a fee-for-service rate schedule have less incentive to control costs.
- *Insurer responsibility for managing performance.* In at least one low saving IPA, network physicians were largely responsible for utilization review and other methods designed to evaluate and improve performance.

2. The Relationship Between Costs and Volume for Humana's IPA Physicians

We estimate that an increase in volume from 100 enrollees to 1,000 enrollees is associated with a reduction in cost per enrollee of 6.4 percent. This result is based on our analysis of the relationship between costs per enrollee for specialty and hospital care and number of IPA enrollees (volume) for a sample of Humana primary care physicians, using regression methods to hold constant actuarial expected costs, market area, and the type of contract that Humana has with the physician. While there are some caveats concerning whether the estimated relationship represents a true causal relationship between volume and costs, the consistency of this relationship with the observations of managers at all of the insurers that participated in this study supports the causal interpretation.

We demonstrate the potential impact of increased volume on IPA savings by a simulation analysis that uses the provider data from Humana along with the regression results described above. If each provider in the sample with fewer than 1,000 patients were to increase his or her volume to 1,000, the regression results imply that specialty and hospital costs per patient for all the providers in the sample would drop by 2.6 percent.

3. Market Area Analysis of Humana and Prudential Plans

For this analysis we examined market area data for Humana and Prudential IPAs as well as for Prudential POS plans and Humana PPOs. For each insurer, year, and network, we divided market areas into high and low costs groups, on the basis of medical cost per member per month, and then examined differences in the features of the networks in the two groups.

The results of this analysis are largely inconclusive. For the most part, the results for volume are consistent with the hypothesis that increases in volume reduce costs. Results for capitated payments for primary care and for financial incentives to control specialty and hospital costs are sometimes consistent with hypothesized effects, but are counter to expectations almost as often.

It would be a mistake to view the mixed results as evidence against the usefulness of capitated payments for primary care and financial incentives to control specialty and hospital costs. Instead, the inconclusive results reflect the very large variation in costs that we found across market areas and the difficulties of identifying the effects of what may only be a small subset of the factors which explain that variation. It would also be a mistake to attribute the results for volume to the effects of volume alone since the data are not rich enough to let us separate the effects of volume from many confounding factors.

B. Implications for Health Reform

The results of this study support the following views:

- Savings that can be achieved by network models of managed care are greater than previously thought.
- Managed care savings can be significantly enhanced by health reform that promotes price competition among insurers.
- Requiring HMOs to offer point-of-service options will significantly undermine potential system savings from increased use of managed care.

Each of these views, and the support provided them by this study, are discussed below.

1. Managed Care Savings

The estimation, or "scoring," of managed care savings from the implementation of any health reform proposal is critical to the health reform debate. All parties to the debate agree that health care costs are "too high," that the health care system delivers care inefficiently, and that a major goal of health reform should be to reduce the growth of health care costs. Some

believe that promotion of managed care can generate substantial savings by squeezing inefficiencies out of the system, while others do not. Policy maker and public support for a particular proposal may hinge on the extent to which a proposal relies on managed care to control costs and perceptions about the effectiveness of managed care in achieving that goal.

The current debate over President Clinton's reform proposal, the Health Security Act (HSA), illustrates the important role of managed care savings. The HSA includes several provisions to control health care costs. One of these is managed competition, a system in which individuals would choose insurance coverage through regional or corporate health alliances. Managed competition is expected to promote enrollment in managed care plans because individuals would have stronger financial incentives than they currently do to choose a low cost insurance plan. Another cost control provision is caps on the growth rate of premium payments to health alliances, which would check insurers' ability to pay for ever increasing expenditures.

Many policy makers are skeptical about the ability of premium caps to control health care spending. They believe that upward pressure on the growth rate of health care costs will result in political pressure to relax the caps. Worse yet, failure to relax the caps may result in severe rationing of health care services, and may also result in the inequitable allocation of health care resources across states and regions.

The success of managed care in reducing health care costs is critical to the success of premium caps under the President's plan. The more successful managed care is in controlling costs, the less necessary it is to rely on premium caps to control costs. If only small savings are scored for managed care, then the expectation will be that premium caps must be relied on heavily to control costs.

The CBO did not score managed care savings in its recent report on the HSA.²⁸ Instead, it assumed that the growth targets for the premium caps would be achieved. The report points out, however, that the premium caps may be politically difficult to sustain and/or may have undesirable consequences for health care unless the economic pressures for faster growth can be relieved. The report states that "Increasing enrollment in tightly managed health care plans -- such as group- or staff-model health maintenance organizations -- might indeed reduce health spending initially but might have little effect on the rate of growth of spending in the longer run."²⁹ This statement reflects CBO's position, expressed in earlier documents (see Chapter II) that network models of managed care do not produce significant savings. The

²⁸Congressional Budget Office, *An Analysis of the Administration's Health Reform Proposal*, Washington, D.C.: U.S. Government Printing Office, February 1994.

²⁹*Ibid.*, p. 75.

report also discusses other sources of savings in the HSA that could relieve the pressure on premium caps, but ultimately the report is silent on how strong that pressure is likely to be, how effective the caps would be in controlling costs, and what the consequences of the caps would be for the quality of health care.

If the CBO were to score large savings from managed care, concerns about the premium caps in the HSA would be less of an issue. More generally, scoring more savings to network models of managed care would favor those proposals that rely on market mechanisms and other features to promote managed care relative to those which rely on benefit limitations and/or regulatory controls, and would also make the President's objective of universal coverage appear to be more feasible.

Our results for Aetna add weight to growing evidence (see Chapter II) that the conventional wisdom about cost savings from network models of managed care is wrong. The savings estimates we obtained for IPAs are much greater than the 0.5 percent savings used by CBO. These small savings include utilization savings alone; they include no discount savings. By comparison, we found four percent utilization savings even after deducting four percentage points for utilization review. We also argue that substantial discount savings -- 10 percentage points, or more -- also represent system savings.

It is, of course, risky to generalize the results from a single study, or even a small group of disparate studies, to other situations, and those who are charged with estimating the costs of health reform proposals are understandably reluctant to use new results which defy widely accepted results unless they are based on exceptionally strong evidence. It is unfortunate, therefore, that reliable estimates of managed care savings are so difficult to produce.

It is also difficult to determine how replacement of CBO's estimates of IPA savings with our own would impact the managed care savings scored for any particular health plan. Many other factors must be taken into consideration, including:

- Large numbers of people are already in HMOs, and managed care enrollment can be expected to increase substantially even in the absence of health reform; only savings from those who switch as a result of the reform should be counted in scoring the savings;
- It is necessary to estimate how many FFS enrollees would switch to managed care for each type of managed care, as well as how many of the uninsured would choose each type of insurance. Additional, smaller savings should be scored for individuals who switch from less tightly managed care to more tightly managed care (e.g., PPO to IPA);
- Managed care plans under reform may or may not continue to have low out-of-pocket costs relative to indemnity plans. Lower out-of-pocket costs would reduce

the savings achieved in comparison to our estimates, which compare plans with comparable out-of-pocket costs;

- The full 10 percent discount figure should probably not be applied to those living in rural areas because price competition among providers is necessarily limited in that setting;
- The full discount figure should also not be applied to Medicaid beneficiaries who join HMOs because Medicaid prices are already discounted well below private prices; and
- Suitable adjustments should be made for any plan provisions which encourage or limit price competition among providers.

Thus, it is very difficult to predict how use of these results would affect the score for any particular reform proposal.³⁰

There is, however, every reason to believe that the findings from recent studies of IPA savings, including this one, are more relevant to projecting future IPA savings than findings from earlier work. First, in general the newer studies are methodologically as sound as the older studies. Second, insurers have gained considerable experience with managing network providers -- experience they did not have at the time earlier studies were done. Third, price competition among insurers has gradually been replacing benefit competition in the last few years as employers and others have paid increasingly more attention to controlling their health care costs, and this may mean that managed care savings today are greater than they used to be.

This last point deserves elaboration. Alain Enthoven argues that the potential for managed care to reduce growth in health care spending has not yet been realized, despite rapid expansion of managed care, because under the current system the main purchasers of private health insurance, namely employer groups, are not very sensitive to price.³¹ There are two reasons for this. First, the tax code allows employers and their employees to make premium payments from pre-tax dollars, while most out-of-pocket expenses must be paid from

³⁰Lewin-VHI's estimates of the cost of the HSA provide an example (*The Financial Impact of the Health Security Act*, December 9, 1993). Use of the results reported here would not have a material impact on our estimates of managed care savings under the HSA. While application of the Aetna based estimate for IPA saving would increase saving for those relatively few individuals predicted to switch from FFS to IPA plans as a result of the HSA, it is inappropriate to apply the full saving because the HSA envisions "low-cost shanng" managed care plans; if we had compared low-cost sharing IPA plans for Aetna to high-cost sharing FFS plans, we would have found less savings. Further, our HSA estimates did not take into account the HSA requirement that all HMO plans include an out-of-network option, which would increase costs.

³¹See Alain C. Enthoven, "Why Managed Care Has Failed to Contain Health Costs," *Health Affairs*, Fall 1993, pp. 27 - 43.

post-tax dollars; hence, there is a strong incentive to increase services covered and limit coinsurance, deductibles, and copays. Second, many employers fix employee contributions at a percentage of the premium payments, so the employee pays less than the full marginal cost of more expensive insurance.

Under these circumstances, managed care plans may find it easier to attract enrollees by offering more generous benefits, rather than by offering the same benefits at a lower price. This may explain why our findings of managed care savings, which carefully control for these factors, exceed those found in many earlier studies. Recent intensification of price competition among insurers, driven by employer and employee concerns about health benefit costs, may also account for an increase in savings.

2. Promotion of Price Competition and Managed Care Savings

If Enthoven's argument that the potential for managed care to reduce spending growth has not yet been realized is correct, a key determinant of managed care savings under health reform will be the extent to which the reform promotes the price competition needed to achieve that potential. According to Enthoven, in order to encourage price competition "[e]mployer and government sponsors need to convert to defined-contribution health benefit programs, limit tax-free employer contributions, standardize benefit coverages within sponsored groups, risk-adjust premiums, group small employers into large health insurance purchasing cooperatives, and require production of reliable data on quality, especially as measured by outcomes." Other things equal, more managed care savings should be scored for proposals that adopt such features than those that don't.

Several findings from our study provide significant weight to the argument that enhancing price competition would increase managed care savings. The first is the finding of great variation in savings among plans of a given type. This demonstrates that there is substantial scope for increased savings under health reform in many market areas.

The second is the finding that savings for Aetna networks appear to be greatest in the markets where HMO penetration and competition among HMOs is greatest. Aetna's regional managers emphasized the intense nature of the competition in those markets that achieved the highest IPA, POS, and PPO savings.

The third is the finding that primary care physicians with many patients from a single IPA produce substantially greater savings than those with just a few, evidently because it is easier for the insurer to influence their behavior. Enhanced price competition among insurers is expected to result in growth in the size of IPAs, and this would be accompanied by growth in

the number of patients per primary care physician. In addition, IPA growth would give IPAs more bargaining power in negotiating with physicians and other providers.

3. Point-of-Service Requirements

The Health Security Act includes a provision that would require all HMOs, including IPAs, to allow enrollees some access to out-of-network services. Enactment of this provision would convert all existing HMO plans to POS plans and effectively limit expansion of managed care to expansion of POS plans or even less restrictive forms of managed care (e.g., PPOs). This provision is attractive to many because it gives all HMO enrollees more freedom to visit out-of-plan providers if they choose, although at a price.

Our findings for Aetna suggest that this requirement would be very costly. The findings show that savings from Aetna's POS plans are 10 percentage points lower than savings from IPA plans. This difference is not affected by adjustments for utilization review or discounts since both apply to both types of plans.

Our results also show that POS and PPO plans are attractive to employers who provide insurance because their savings on costs covered by the plan are essentially the same as for IPAs (23 percent for both POS and PPO plans, compared to 26 percent for IPAs). The difference in savings arises because enrollees in POS and PPO plans have much higher out-of-pocket costs. This is the price that enrollees pay for their greater freedom of choice.

While some may judge the freedom of choice provided by POS requirements to be worth the price, it must be recognized that such requirements will greatly reduce the ability of managed care to control the growth of health care costs. Existence of such a requirement in any reform proposal must be taken into account when scoring the savings from managed care.

C. Effects of Managed Care on the Long Term Growth Rate of Health Care Costs

The results of this study and other recent research provide reason for optimism that increased enrollment in managed care plans will reduce health care costs, but they do not imply that increased enrollment will permanently slow the growth rate of health care costs. Once managed care has played its role in removing inefficiency from the health care system, cost growth could return to its high, historical rate.

Increased use of managed care in a price-competitive environment should, in theory, result in a permanently lower growth rate of health care costs. In such an environment,

managed care providers would be encouraged to continually adopt new technologies and innovative delivery practices that are cost-effective. There is, however, no convincing empirical evidence on the size of the permanent growth rate reduction, if any exists at all.

Even a small reduction in the growth rate -- one or two percentage points -- would have a very large cumulative effect on costs after just a few years. Evidence from the actuarial trend factors of major insurance companies, discussed below, indicates that the reductions could be this large or larger, but the evidence is not definitive.

Actuarial trend factors are expected growth rates for medical costs paid by insurers. They are used by actuaries to price renewals of existing group policies, and generally assume no change in the benefit package and no change in other factors that might affect a group's claims experience.

The average trends over the last three years for a large sample of companies show consistently slower premium growth for managed care products than for indemnity products (Exhibit V.1).³² In comparison to managed indemnity premium growth: HMO premium growth has been six to nine percentage points lower in each year; POS premium growth has been four to six points lower; and PPO premium growth has been two to three points lower. While some of these differences are probably explained by factors other than the effect of managed care on growth in health care costs, the differences are large enough -- especially for HMOs -- to be consistent with a substantial role for the effect of managed care on long term growth rates.

EXHIBIT V.1

Average Actuarial Trend Factors by Insurance Type, 1991 to 1993

	1991*	1992*	1993
Managed Indemnity	22%	19%	18%
Preferred Provider Organizations	19%	17%	15%
Point-of-Service Plans	16%	15%	13%
Health Maintenance Organizations**	13%	12%	12%

*1991 and 1992 figures are for August renewals; 1993 figures are for October renewals

**Predominantly IPAs.

Source: Tillinghast, Inc.

³²The averages in Exhibit V.1 are from a series of non-random surveys of large insurers, conducted by Tillinghast, Inc. The 1991 and 1992 surveys included 16 companies, and the 1993 survey included 20. Not all companies reported trend factors for all insurance types, and differences in averages across types may reflect, in part, differences in the companies included. Evidence we have reviewed from a few individual companies that offer all products suggests, however, that this is not the case.

Other explanations of differences in trend factors include:

- continued cost shifting from managed care patients to indemnity patients;
- increases in biased selection;
- the gradual separation of providers into low-cost providers who serve managed care patients and high-cost providers who serve indemnity patients;
- faster growth in costs for the treatment of conditions that are more prevalent among indemnity enrollees; and
- differences in "leverage" -- the effect that inflation has on claims costs paid by the insurer when deductibles and stop losses are fixed in nominal terms, as they are when determining trend factors.

Our current knowledge about the importance of each of these factors is very limited, with the exception of the last. Leverage is routinely calculated by actuaries, and the difference between leverage for managed indemnity plans and managed care plans is typically less than one percentage point. Substantial additional research would be required to separate the effects of the other factors listed from the effect that managed care may well have on the permanent growth rate of health care costs.

Appendix A

AN ECONOMIC MODEL OF PROVIDER DISCOUNTS

The economic model presented in this section provides a strong theoretical reason to believe that HMO discounts represent real system savings: HMOs induce price competition among providers. That is, HMO demand for provider services is more price sensitive than FFS demand, and this reduces providers' ability to obtain economic profits. In the model examined, discounts represent the difference between a provider's economic profits on FFS and HMO patients. There is no reason to believe that discounts will become insubstantial as more and more people join HMOs. Nor is there any reason to believe that higher HMO enrollment will push up FFS prices, shifting costs for HMO patients onto FFS patients.

In order to clarify the nature of HMO discounts and to better understand the extent to which they represent system savings, it is helpful to first consider the profit-maximizing strategy of a hypothetical provider who serves only FFS patients and then compare it to the same provider's strategy when offered the opportunity to care for HMO patients at a discounted price. After making that comparison, we then examine how discounts are likely to change when enrollment shifts from FFS plans to HMOs. We first consider a short run scenario, when some provider inputs are fixed (e.g., hospital beds), then turn to the long run, when all inputs can be optimally adjusted to minimize costs.

The generic "provider" in the analysis could be a hospital, a physician, or any other provider of medical services. We ignore the issue of risk associated with uncertain utilization for simplicity; while risk is obviously important in the market for health care services, it is not material to the fundamental points that are demonstrated.

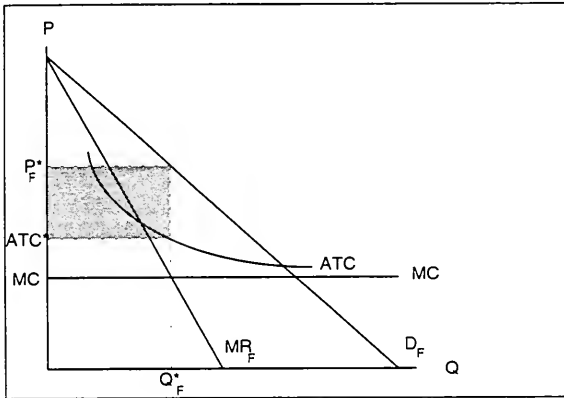
We assume that the profit-maximizing provider faces a downward sloping demand curve for services from FFS patients because such patients have only small incentives to consider price when choosing a provider (see D_F in Exhibit A.1).³³ Marginal revenue from FFS patients (MR_F) -- the additional revenue obtained by lowering the price enough to sell one more unit -- is below the price on the demand curve at every level of services sold (Q) because the provider must lower the price on all units sold to induce additional purchases, not just on the last unit sold. To simplify the analysis, we have assumed that the producer's marginal costs (MC) are

³³This diagram is the standard diagram from microeconomic texts for the case of a single producer facing a downward sloping demand curve.

constant.³⁴ Average total costs (ATC) decline with Q because they are the sum of average fixed costs, which decline with Q as fixed costs are averaged over an increasingly large number of units, and the constant marginal cost.

Profit is maximized at the quantity where marginal revenue just equals marginal cost (Q_F^*). The maximum price the provider can sell this quantity for is the price on the demand curve over Q_F^* (P_F^*), average total cost at this quantity is the value on the ATC curve over Q_F^* (ATC^*), unit profit is the difference between these two, and total profits are this difference times Q_F^* (the shaded area).

EXHIBIT A.1
A Profit-Maximizing Provider

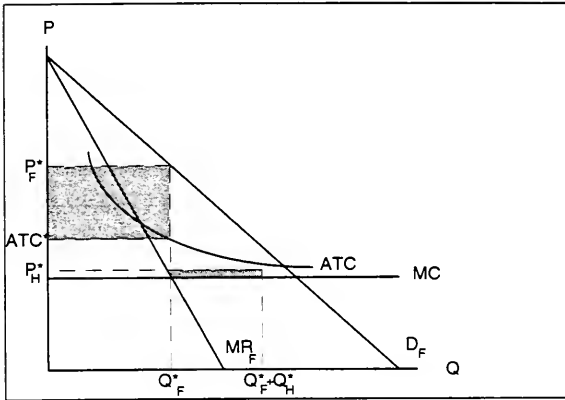


Now suppose the provider has an opportunity to sell an additional Q_H^* units of output at price P_H^* , where P_H^* is at least as large as MC (Exhibit A.2). Each additional unit sold at this price yields additional profits of $P_H^* - MC$ because selling additional units does not change fixed costs; additional profits are equal to this difference times the number of units sold to the HMO (the smaller shaded area). Thus, the provider's profits will increase if the offer is accepted.

³⁴We think this assumption is realistic over a wide range of outcomes in situations where the provider has substantial excess capacity. As capacity is used up, however, short-run MC must eventually rise.

EXHIBIT A.2

A Price Discriminating Provider in the Short Run



The profit-maximizing price for FFS patients does not depend on the opportunity to provide services to the HMO's patients. The provider has already chosen the price that maximizes the profits to be earned from the FFS patients. The HMO receives a discount, equal to $P_F^* - P_H^*$. In the example the HMO pays less than average cost for its patients, while the FFS patients pay more than average cost. This situation is sometimes confused with cost shifting, but it is not cost shifting because acceptance of the HMO's offer does not cause the FFS price to increase.

In order to determine whether the HMO discount represents system savings it is helpful to consider what would happen if some of the price-discriminating provider's FFS patients switched to the HMO. Under such an enrollment shift, the FFS demand and MR curves shift down and to the left. The MR curve will now intersect MC at a lower value of Q (i.e., services provided to FFS customers will fall). It can be shown that P_F^* will be unchanged if the "elasticity of demand" -- the percentage change in quantity demanded per percentage change in price -- on the new demand curve at P_F^* is the same as on the old demand curve, provided

also that MC is constant, as assumed.³⁵ Departures from these assumptions could lead to increases or decreases in P_F^* , but there is no obvious reason to believe they would be large in either direction.³⁶

The enrollment shift will also increase Q_H^* , although by less than the decrease in Q_F^* if the shift to the HMO has a negative utilization effect. As long as profits remain positive, the provider will still be better off serving the HMO patients at price P_H^* than not serving them at all. At that price, total profits will go down both because fewer total units will be sold and because some units that were previously sold at price P_F^* are now sold at the discounted price, P_H^* . Both these changes -- the utilization reduction and the discount -- are real system savings.

The provider cannot, however, be expected to continue selling services to the HMO at price P_H^* if enrollment shifts continue indefinitely; eventually profits will become negative and the provider would be better off (i.e., minimize losses) by going out of business. Presumably the provider would try to negotiate a higher price with the HMO, and the HMO might accept, depending on the alternatives available.

What happens in the long run depends both on costs in the long run, when no costs are fixed, and on the alternatives available to the HMO. Suppose that long run marginal cost is constant -- by expanding or contracting all inputs in an efficient manner the provider can produce any number of additional units at the same cost per additional unit -- and that there is a downward sloping HMO demand curve which is substantially more elastic than the FFS demand curve (D_H in Exhibit A.3). The HMO demand curve can be expected to be substantially more elastic than the FFS demand curve because, other things equal, HMOs direct their patients to the lowest price providers, and FFS plans do not.

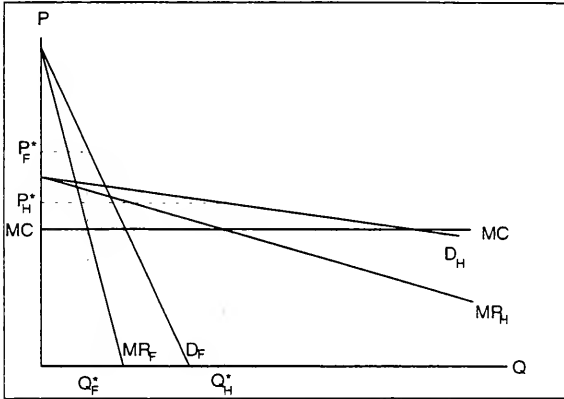
The provider maximizes profits by setting the FFS price so that FFS marginal revenue (MR_F) is just equal to marginal cost (as before) and by simultaneously setting the HMO price so that HMO marginal revenue (MR_H) is also just equal to marginal cost. The HMO price is below the FFS price because the HMO demand curve is more elastic; the provider will not increase the HMO price to the FFS price because to do so would result in a very large reduction of services sold to HMOs. Thus, an HMO discount remains. If enrollment continues to shift from FFS plans to HMO plans, the discount may increase, decrease, or remain the same. Just as with the FFS price in the short run, there is no reason to believe that there would be a

³⁵This result follows directly from the well known result that $MR = P(1 + 1/\eta)$, where η is the (negative) elasticity of demand. If the shift in the demand curve does not change the elasticity of demand at any given price, then MR is also unchanged at that same price. Thus, under this condition, and given constant MC, MR will be equated to MC at the same price as before the shift.

³⁶Note especially that departures from constant MC would have little effect unless total utilization changed a lot.

substantial increase or decrease in either the FFS or HMO profit-maximizing price as this shift continues. Substantial discounts can be expected to remain as long as there are any FFS patients available to pay higher prices, and enrollment shifts from FFS to HMO plans will continue to reduce system costs through both utilization savings and discount savings.

EXHIBIT A.3
A Price Discriminating Provider in the Long Run



An interesting feature of this model is that percentage discounts depend only on the elasticities of demand for FFS and HMO patients; they do not depend on the structure of costs. It can be shown that the profit-maximizing price charged HMO patients relative to that charged FFS patients can be written as

$$\frac{P_H}{P_F} = \frac{1 + \frac{1}{\eta_F}}{1 + \frac{1}{\eta_H}}$$

where η_F and η_H are the elasticities of demand for FFS and HMO patients, respectively.³⁷ As long as the provider profit-maximizes, the only factor that would have an effect on percentage discounts would be a change in one of the elasticities; the structure of costs does not matter.

³⁷The two profit-maximizing conditions can be written as $MR_F = P_F(1 + 1/\eta_F) = MC$ and $MR_H = P_H(1 + 1/\eta_H) = MC$, from which the result follows immediately.

Appendix B

TECHNICAL SPECIFICATIONS FOR THE ANALYSIS OF THE RELATIONSHIP BETWEEN COST AND VOLUME FOR HUMANA'S IPA PHYSICIANS

A. Data

Humana provided 1991 data for 1,623 IPA physicians and 1992 data for 1,679. We ultimately used 1991 data for only 815 physicians and 1992 data for only 863. Data for others were excluded for one of several reasons: (1) the physician was not a primary care physician (PCP); (2) the data were incomplete; (3) the physician received fee-for-service payments, rather than a capitated payment, for primary care; and (4) the contracting physician represented a physician group. The last of these reasons accounts for 1,183 of the excluded observations. The reason we excluded these observations is that we could not compute our volume measure, members per PCP, because we were unable to determine the number of PCPs in the group.³⁸ Another 283 observations were excluded because the PCP received fee-for-service payments. Most of these were physicians who had just joined the network and had very few enrollees.³⁹

B. Methodology

We discuss the functional form used for the multiple regressions in the first section. In the second subsection we discuss how we handled the problem of extreme outliers that arises because, in any particular year, a PCP may have one or more extremely high cost enrollees, or may, at the other extreme, have enrollees that use very little care. In the third subsection we discuss the weights used in the regression analysis.

1. Functional Form

The focus of our analysis was an examination of how actual costs varied with volume across PCPs holding expected costs, PCP specialty, market area, contract type, and year

³⁸Many of the PCPs included in the final sample were members of practice groups, but were individually enrolled in the IPA.

³⁹Humana sometimes pays PCPs that are new to the network on a fee-for-service basis if the number of IPA members using the PCP is very small. We eliminated these observations to avoid confounding the relationship between volume and costs with the relationship between payment method and costs.

constant. We used (weighted) multiple regression to estimate relationships of the following general form:

$$\frac{\text{Cost}}{\text{Expected Cost}} = a_0 + f(\text{Volume}) + a_1 \text{Dummy}_1 + a_2 \text{Dummy}_2 + \dots + a_K \text{Dummy}_K + \varepsilon$$

where: a_0 is the regression intercept; $f(\text{Volume})$ represents a non-linear function of *Volume*, to be discussed further below; Dummy_1 through Dummy_K represent a combination of the *Specialty*, *Market*, *Contract*, and *Year* dummies; a_1 through a_K represent the dummy coefficients; and ε represents the regression error. We refer to the ratio of *Cost* to *Expected Cost* as the *Cost Ratio* in the discussion below.

We experimented with the specification of the functional form for $f(\text{Volume})$. As discussed in the introduction, on the basis of conversations with the insurers we expected a negative relationship between the *Cost Ratio* and *Volume*, holding other things constant, but one that diminished as *Volume* increased. We focused on non-linear functional forms which were sufficiently general to yield results that were consistent with these expectations, yet simple. The two candidates considered most carefully were the following "quadratic" and "logarithmic" forms:

$$f(\text{Volume}) = b_1 \text{Volume} + b_2 \text{Volume}^2$$

and

$$f(\text{Volume}) = c \text{Ln}(\text{Volume}),$$

respectively, where $\text{Ln}(\cdot)$ represents the (natural) logarithmic function. Statisticians commonly use these forms in specifying non-linear regression models. The quadratic form yields the hypothesized relationship if the coefficient b_1 is negative and the coefficient b_2 is positive. The logarithmic form yields the hypothesized relationship if the coefficient c is negative.

To discriminate between these two forms, we estimated each using both the full sample of PCPs and three subsamples defined by eliminating observations with *Volume* greater than 700, 500, and 300, respectively. Since truncating the sample on the basis of an explanatory variable in this fashion does not bias the results for a correctly specified model, the coefficients of the *Volume* variables should not change very much as observations are eliminated on this basis if the correct functional form is used.

For the quadratic function, the estimated relationship had the expected shape, but the strength of the relationship became stronger as the sample was truncated. Thus, the curvature obtained under the quadratic function was not sufficient to capture the rapidity with which the relationship diminishes as *Volume* increases. We found the results for the logarithmic function

to be much more robust to the truncation, although it appears that this form, too, does not allow as much curvature as might be warranted. Results for the logarithmic function are reported in Exhibit B.1 for the full sample as well as for the three subsamples.

EXHIBIT B.1

Provider Regression Results^a

Statistic	Maximum <i>Volume</i> in Sample ^b			
	No Limit	700	500	300
Coefficient of Ln(<i>Volume</i>)	-.028	-0.33	-0.030	-0.045
t-statistic	2.3	2.0	1.6	1.9
P-value (one-sided)	0.01	0.02	0.05	0.03
R ²	0.51	0.48	0.45	0.41
Sample Size	1,656	1,572	1,463	1,259
Number of Control Variables ^c	81	80	79	77

^aStatistics are from regression of the *Cost Ratio* (cost for specialty and hospital care divided by expected costs) on the natural log of *Volume* [Ln(*Volume*)] and a set of control variables. The square root of *Volume* was used to weight the regression.

^bAll observations for PCPs with *Volume* in excess of value indicated were excluded from the sample.

^cControl variables include dummy variables for *Year*, *Market*, and *Contract*, plus interactions between *Year* and *Market* and *Contract* and *Market*. The number of control variables varies as observations are excluded because some combinations of *Contract* and *Market* are no longer in the sample.

As seen in the exhibit, the coefficient of the *Volume* variable, Ln(*Volume*), does not change very much when PCPs with *Volume* in excess of 700 or 500 are deleted from the sample. The coefficient does increase by about 50 percent when PCPs with *Volume* in excess of 300 are deleted, suggesting an even stronger relationship between the *Cost Ratio* and *Volume* for the lowest volume PCPs. We are reluctant, however, to draw this conclusion because there is also a roughly 50 percent increase in the standard error of the estimated coefficient. This also suggests that the estimates using the full sample may somewhat understate the rate at which the negative relationship between the *Cost Ratio* and *Volume* diminishes; perhaps, as the insurers have suggested, the relationship essentially disappears once *Volume* reaches approximately 500.

The number of control variables for *Year*, *Market*, and *Contract* in each regression are reported in the last line of Exhibit B.1. This includes interaction variables.⁴⁰ The *Year* dummy was interacted with the *Market* variable to control for market-wide shifts in actual costs relative to expected costs from one year to the next. The *Contract* dummies were also interacted with the *Market* dummies because the exact specification of contracts varies from market to market within contract type. Most markets were dominated by one type of contract, and many of the 21 other contract types were not used at all; if a contract was not used in a market area, the corresponding *Contract-Market* interaction term was omitted. In all, 81 dummy variables, including interactions, were included.

2. Outliers

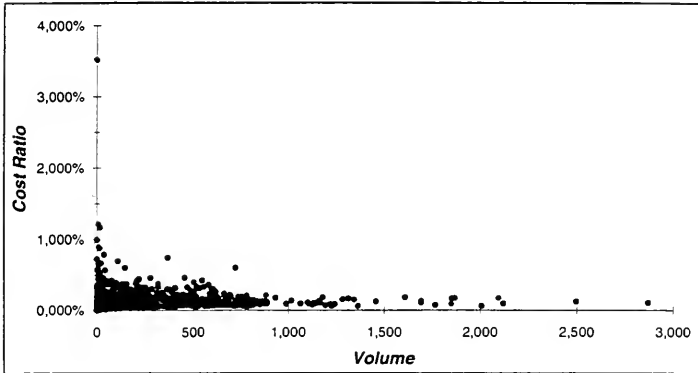
A few PCPs in our sample had extremely high *Cost Ratios*. This was presumably due to the presence of one or more enrollees with extremely high cost illnesses. There were also a very few PCPs with extremely low *Cost Ratios*, presumably due to an unusually large proportion of enrollees with very low costs.

Extreme outliers have a very large effect on regression results. In general, they are likely to obscure the relationship between the explanatory variable(s) and the dependent variable. Hence, they are often "trimmed" (i.e., eliminated from the sample), according to some reasonable criterion.

The obvious outliers in our sample are very low volume PCPs; one such PCP has a *Cost Ratios* of 3,500 percent; i.e., this PCP's actual costs exceed expected costs by 3,400 percent. This outlier and other outliers are clearly visible in the "scatter diagram" that appears in Exhibit B.2. In this diagram, each point represents one PCP in our sample; *Volume* is measured on the horizontal axis and *Relative Cost* is measured on the vertical axis. While no other PCP has a ratio nearly as high as 3,500 percent, a number have ratios in excess of 500 percent, and most of these have very low volume.

⁴⁰Dummy interactions" are variables that are the product of two dummies, and are dummies themselves. For instance, the product of the dummy variable for "market a" and "contract type i" is a dummy variable that indicates whether the PCP "is from market a and has contract type i" or not.

EXHIBIT B.2

Scatter Diagram of *Cost Ratio* vs. *Volume* for Humana PCPs

Presumably the high costs for these low volume PCP's are due to the presence of a few very high cost patients among a small number of patients. *Cost Ratios* that are this high are very unlikely among high volume PCPs because costs are averaged over a larger group of patients.

Low cost outliers are less obvious because the *Cost Ratio* has a minimum value of zero; thus a *Cost Ratio* as low as zero does not appear to be as extreme as a ratio of 500 percent. *Cost Ratios* as low as 1.5 percent are observed among very low volume PCPs, but only for very low volume PCPs.

Extreme good or bad luck among high volume PCPs is less obvious because of their high volume. A *Cost Ratio* of 200 percent for a PCP with 1,000 members may represent just as extreme bad luck as a *Cost Ratio* of 3,000 percent for a low volume PCP. The reason that outliers are less obvious for high volume PCPs is that costs are averaged over larger numbers of patients. As a result, the variation in the *Cost Ratio* around its mean diminishes as volume increases, as is clearly evident in Exhibit B.2.

Since low cost outliers and outliers among high volume PCPs are less obvious than high cost outliers among high volume PCPs, if we were to trim just obvious outliers by an arbitrary criterion (e.g., if the *Cost Ratio* exceeds 500 percent) we would obtain estimates that might substantially understate the strength of any negative relationship between the *Cost Ratio* and *Volume*. Instead, we developed a criterion based on statistical theory that treats low cost and

high cost outliers symmetrically and takes the PCP's volume into account. The criterion still introduces some bias against finding a negative relationship between the *Cost Ratio* and *Volume*, but it is much smaller.

THE CRITERION FOR TRIMMING OUTLIERS

The criterion is based on the assumption that the *Cost Ratio* for each PCP represents the outcome of a random process which, for each PCP, can be represented by a specific distribution (a variant of the Chi-square distribution) that depends on *Volume*.⁴¹ This distribution has characteristics that are consistent with the two most obvious features of the diagram: the variance in the *Cost Ratio* around the mean decreases with *Volume*, and the distribution gradually goes from an "asymmetric" distribution with a long positive tail for low *Volume* PCPs to one that is essentially symmetric around the mean. Using this distribution, we checked each PCP's *Cost Ratio* to determine whether the probability of observing a value either as high or as low as the PCP's value was less than one percent; if it was, we eliminated the observation from the sample.⁴²

In all, 22 observations were trimmed. We compared the estimates after trimming the outliers to estimates using the full sample. The main effect of trimming was improvement in the accuracy of the estimates (i.e., smaller standard errors); the magnitudes of the coefficients did not change appreciably. We also estimated the models after trimming observations with costs that, according to our distributional assumptions, had less than a five percent chance of turning out to be what they were. This did not have an appreciable effect on either the coefficients or their standard errors.

3. Regression Weights

In estimating each regression, we weighted the data for each physician by the square root of *Volume*. The reason for this stems from the fact that the regression error for each PCP, ϵ , is an average of errors for the PCP's individual patients. That is, for each PCP some patients will have higher than expected costs, given *Volume* and the other explanatory variables, and others will have lower than expected costs; ϵ represents the average of these individual differences.

⁴¹The distribution developed was based on the assumption that the distribution for a single patient's cost ratio is a linear function of a squared standard normal variable. The intercept and slope of the function are determined by the mean and the standard deviation of costs across all patients. Under this assumption, if a PCP's patients are random draws from the distributions of all patients, the average cost for the PCP's patients is the same linear function of a Chi-square distribution divided by its degrees of freedom (d.f.), and the d.f. is the number of patients. The Chi-square distribution approaches the normal distribution as the d.f. increase, and the approximation is very close for d.f. of 100 or more; hence, the approximating normal distribution was used for PCPs with *Volume* greater than 100.

⁴²The use of the criterion developed does introduce a slight bias against finding a negative relationship between the *Cost Ratio* and *Volume*, but one which is trivial in comparison to the bias that would likely result if a more arbitrary rule was used. The bias is introduced because the assumes that there is no relationship between the mean of the *Cost Ratio* and *Volume*.

As a result, the variance of the regression error is expected to be higher among physicians with low *Volume* than among those with high *Volume*, as is evident if Exhibit B.2; in fact, the variance of ϵ can be shown to be inversely proportional to *Volume*. Weighting the data by the square root of volume increases the weight placed on observations with high *Volume* in determining the estimates. This commonly used weighting method increases the accuracy of the estimates (i.e., reduces the error due to random variation in costs) because the regression errors for high volume observations are less likely to be substantially different from zero; it does not bias the resulting estimate.

Ms. NORTON. Thank, very much, Dr. Morris. Let me ask you some basic questions before we get to particulars.

Is it conceivable that every physician in a given geographical area could qualify for this program, or must some be deselected?

Dr. MORRIS. The evaluation process all relies on comparing physicians to one another. By ranking them against one another it is not likely that we will select every physician in the area, but there is, in fact, no ceiling put on the number of physicians that will exceed the criteria.

Ms. NORTON. Part of what we are trying to achieve in health care reform is rank competition.

Dr. MORRIS. Yes.

Ms. NORTON. It is certainly conceivable to me there would be areas of the country where—particularly given the quality of physicians in this country—where if you are marking on a curve, you are eliminating people who are just not any different. It is like if you have—statistically, if someone gets a score of 96.2 and you say to someone with a score of 96, there is a pattern, statistically you are not compelling.

So I am just trying to understand, therefore, whether given each physician's capacity in given areas regarding quality, and given the nature of practice and patient care, are there areas where every physician might indeed qualify; or must some physicians be dropped under the SPPP?

Dr. MORRIS. I would begin with one of our assumptions that, in fact, we feel amongst the physicians we evaluated there are, in fact, no measurable differences in the quality of care.

Ms. NORTON. That is why I gave you a different hypothetical, Dr. Morris.

Dr. MORRIS. Moving beyond that point, once we established the even base line of quality, there are very dramatic differences in the way physicians in this community practice and provide care to their patients, with ultimately equal outcomes, as best our—

Ms. NORTON. So my hypothetical, even in parts of this community, just would not occur.

We are talking about the Washington metropolitan area now, not just the District of Columbia alone?

Dr. MORRIS. Yes, and actually based on that data—that, I could bring you, as much as you would like to see—that, in fact, physicians practice along a narrow range of quality.

Ms. NORTON. Could the SPPP leave a given area with no given specialties?

Dr. MORRIS. No, none.

No, by design, we have divided the city and the metropolitan area into several geographic areas and physicians within each of those geographic areas are only compared to other physicians for a selection purpose within that geographic area. Therefore, they can never all select out.

Ms. NORTON. A lot of them can given what happened to OB/GYN. A lot of them can.

Dr. MORRIS. Well—

Ms. NORTON. In areas of the District of Columbia where there are the most births and most children.

Dr. MORRIS. I don't know where those numbers came from, so I can't really address the number that you just referenced; but in fact, I can tell you that by design of the process—and in fact, I can show you the results of the process—that, in fact, there are no areas where we have selected out all the doctors in any given area.

Ms. NORTON. Did you take into account whether there was a disproportionate effect in a geographical area where there may be a greater patient composition? That is to say, in X area—say, Southeast Washington selects out—imagine, by the way, what it takes to get a physician to practice in a poor neighborhood.

Dr. MORRIS. Right.

Ms. NORTON. All right. You get a physician in, of all things, OB/GYN which people don't want to practice in the most upscale communities, and he wants to practice and does practice in Southeast Washington. Most of our births are in Southeast Washington. Would you look at the birth incidence in deciding whether or not you should have more physicians to serve that population in Southeast Washington?

Dr. MORRIS. Explicit in the selection process we look at, in fact, the volume of services that were delivered in that particular area and looking at that data—in fact, in using the services that subscribers have used for those who seek services in the area and looking at the physicians who provide that care within those areas, it is explicitly accounted for in the selection process.

One of our objectives, quite frankly, is to minimize the amount of disruption. It does not work to our advantage to create disruption, and therefore, we created a process designed, in fact, to identify explicitly and to minimize disruption created—

Ms. NORTON. Let me ask you, Dr. Morris, and I want you to get together—

Dr. MORRIS. Sorry?

Ms. NORTON. If you dispute or don't know these figures, I want you to get together with the D.C. Medical Society because they say that the number of OB/GYNs in Northeast and Southeast Washington went from 38 to 7, an 82 percent reduction; and in the rest of Washington, the number of OB/GYNs went from 161 to 112, or a 30 percent reduction.

We don't have a lot of births on Capitol Hill where I live, I will tell you that. I have trouble finding kids for my kids to play with. Kids in this city are found in Southeast and Northeast.

If these figures are incorrect, I would like you to submit other figures so we have the right ones. They are terrifying, if they are correct, because I can't imagine what it took to get physicians to go there in the first place; and if you yank them out, not because of crime or heavy practice but Blue Cross/Blue Shield won't fund them anymore would distress me to no end.

Dr. MORRIS. We can do that. I can share with you data I was able to gather between last night and today that—just going through the list, there are at least 178 physicians in Northeast and Southeast DC. which already suggest that the number there is incorrect.

I would also look at OB/GYN data from the Washingtonian where they listed 53, 45 participate and 30 of them, or 67 percent of them, participate in our plan.

Ms. NORTON. I would like those figures corrected after you have met with the Medical Society and submitted them for our record. [The information referred to follows:]

Currently, 210 OB/GYNs in the District of Columbia participate with Blue Cross and Blue Shield of the National Capital Area. Of these, 188 participate in the original Preferred Provider Plan and 150 participate in the Select Preferred Provider Plan. For NE and SE, the breakdown is as follows:

	Participating	Preferred Provider	Select Preferred Provider
NE	16	14	8
SE	23	21	9

We are scheduled to meet with representatives of the Medical Society on September 1, and will share these numbers with them at that time.

Ms. NORTON. Let me ask you another question. The way in which people go to doctors in this country, especially doctors in certain practices, often breaks down along racial lines. In fact, in many communities only people of a certain race will go into the community.

Now, is it conceivable that your computer program could produce a result where every black physician in a section of the city or in a specialty was deselected? Can you assure me that that simply could not happen?

Dr. MORRIS. We have no data or information regarding the race of our—

Ms. NORTON. You had better get some, if I may say so. The way in which medicine is practiced in this country is such that if you have no data on race, what you are saying, for example, to somebody who may live in an area where there is a teaching hospital—although that person is a poor person, what you are saying to that person is that the habits which sent her to the physician in her neighborhood are going to be broken; and we had a hard enough time getting her to go to any physician.

So if you have no information on that, given the realities of medical practice in this country and what it has taken to get people to go into low-income neighborhoods, then I am not assured that people in those neighborhoods will continue to be served, just because you have some physician somewhere up there in a teaching hospital—if she could find her way into the hospital—who would, in fact, serve her.

Dr. MORRIS. Although I don't have the information on race I can assure you that, in fact, those physicians who are in Southeast D.C., for example, were only compared to those doctors in Southeast; and in fact, we did not deselect all those doctors, so—

Ms. NORTON. Dr. Morris, I am being very careful about my hypothetical. You could have a physician in a hospital who was in the same specialty, or an internist in the hospital; but in fact, the black physicians are in a neighborhood where those in the hospital wouldn't dare to go. And it matters, therefore, if we are to provide health care in our neighborhoods, that the people who, in fact, are willing to serve them continue to be selected by plans that serve them.

So I am being very specific about my hypothetical. I know there may be somebody left there in the specialty, but I am asking you if you have any way of knowing whether that physician left there

has any relationship or would, in fact, form any relationship to the people who live in that community? That is why I asked about race.

There could be other indicators; you could ask them whether or not they served people in the neighborhood or you could look to something that we know indicates they are serving in the—if they are located on Martin Luther King Avenue, for example, they are serving in the neighborhood. That might be another way to look at it. Or if they are black, given the habits of race in this country, they are most likely serving black people.

But if it is not in your computer program, then I have no way of knowing whether or not the qualified physician left somewhere in the area but maybe in a hospital, is in fact going to or will provide or would even consider providing service to the people in that neighborhood.

That is my concern.

Dr. MORRIS. Right. That concern is understood. I have no indication other than the fact they have established practices in those neighborhoods, but I cannot document any further than that situation.

Ms. NORTON. You rightly said and justifiably said and we all understand, we are beginning to understand this process. You are trying to perfect the process. I am totally in sympathy with that, especially in light of the need that we are inexorably putting on you in this Congress to bring down the cost of service.

In the process of doing the computer programs or understanding what you are about, of perfecting your own learning curve, it seems to me it would be important to test for some factors so you could satisfy yourself that, in fact, hypotheticals like the one I just gave don't come to hit you in the face. And they will hit you very hard if, in fact, over time, we found that to be the case.

You may be able to explain this away simply by checking on it. I am not very receptive to the notion that we don't look at race. You are speaking to the former Chair of the Equal Opportunity Employment Commission, and not looking at race before Title VII was passed meant discrimination, and it was unintentional; people just didn't factor race in.

Unfortunately, life factors race in for people who live in Southeast and Northeast Washington, and we have to begin to know whether or not these plans are having a racial effect.

So I would ask you to at least look at that, even if it is not in your ordinary programs, so that you can be assured that you will not be hit with the notion that there was insensitivity in setting up these programs in light of the people who must live under them.

May I ask you about the notion that every doctor at a teaching hospital was automatically included in the SPPP without the Pro/File evaluation required.

Dr. MORRIS. Yes. The teaching hospitals were, in fact, included in the network as were some other categories of providers without the benefit of the evaluation process. We feel for a number of reasons that it was important to have a teaching facility in the network because of the very specialized services they provide, because of quality issues, and also because of some marketing issues and

our ability to have subscribers feel comfortable that they have access to what they perceive to be high-quality medical care.

Ms. NORTON. You are depending on the evaluation of the hospital of its own physicians?

Dr. MORRIS. No, I have the ability to work directly with the hospitals and with the faculty in order to deal with and address issues. I have data and information regarding their practices, and that information has been shared with them also.

Ms. NORTON. I am sorry, you have data what?

Dr. MORRIS. I also have data about their practice patterns, and that data has been shared with them also.

Ms. NORTON. The practice patterns of—

Dr. MORRIS. Of the collective faculty practices.

Ms. NORTON. So it is inconceivable that anybody there in a faculty practice has a practice that would disqualify that person, deselect that person, if that person were not in a teaching hospital. That is inconceivable?

Dr. MORRIS. I am sorry, I am not sure what you are asking.

Ms. NORTON. What I am asking is, is it possible that there is a doctor in a teaching facility whose evaluation would deselect her if she were not affiliated with the teaching facility?

Dr. MORRIS. The answer to that is, yes, just as there are physicians who are not affiliated with teaching facilities who were selected that if we were to look at their individual practice patterns would not have been selected, also; the point being that the unit we actually evaluated is what we call the practice.

In other words, any group of people who have come together collectively to provide medicine under some common legal umbrella, that have an agreement with Blue Cross/Blue Shield, that is the entity we evaluate; so if there is an individual physician in private practice, that is the unit of practice we evaluated.

If there were 12 physicians—that is, they worked together—the collective practice pattern is what we evaluated. The same applies to the faculty practice plans; we evaluated them as a whole, not as individual physicians within those group practices. Again, that principle applies to those who were not involved in faculty practices, also.

So the individual physician is not what was evaluated in this process. It was the practice that was, in fact, evaluated.

Ms. NORTON. How does one evaluate a practice?

Dr. MORRIS. When health—

Ms. NORTON. Without looking at the individual physicians—excuse me.

How does one conceivably evaluate the practice without looking at the records of those who make up the practice?

Dr. MORRIS. When physicians provide services, health services for patients, they—physicians—submit claims; on those claims is a wealth of information that we are able to extract from those claims, not simply what the charges were, but we certainly know a lot about the patient demographics, about the kinds of services the patient receives, we can learn how long the patients were in the hospital, what the diagnoses were. We can learn a wealth of things about their care and about what happened to them from that database of information.

This process is not designed to look at the individual specific visit that occurs. We, in fact, recognize that sometimes people—physicians—perform well and do well, and sometimes they do less well, but the objective is to look at how they perform over time. We can look at this through looking at thousands and thousands of pieces of information we are able to accumulate regarding a physician's practice patterns.

Ms. NORTON. Dr. Morris, I will ask you to forgive me, I have two bills which I must manage on the floor. I have read your testimony, and I think your testimony does, in fact, answer some of the questions. I am going to ask Ms. Byrne if she would do me the great favor of taking the Chair now, because I have no choice but to go to the floor when my number comes up, and I have just been informed that my number is up.

I want to thank you for appearing, and ask Mrs. Byrne to continue, and if I am not back, to conclude the hearing.

Thank you very much.

Dr. MORRIS. Thank you for the opportunity to present to you.

Mrs. BYRNE [presiding]. Dr. Morris, there is a tremendous amount of interest in this whole pro/file software. According to your testimony, you use Health Services Analysis; is that the company that designed this software?

Dr. MORRIS. That is correct.

Mrs. BYRNE. Did Blue Cross/Blue Shield have any initial input or help with the design of the software, or was this all—did Health Services Analysis come up with it?

Dr. MORRIS. No, representatives of our organization, including a number of outside consultants, were involved in its development.

Mrs. BYRNE. Would it be possible for us to get a profile of pro/file, what is included in the criteria, the selection criteria? I am still not clear on what is actually there.

Dr. MORRIS. The selection criteria themselves are not what traditionally have been perceived to be selection criteria. The selection criteria were, in fact, criteria that deal with how physicians compared to one another on overall practice patterns. So it relates to whether they were in the top quartiles or lower quartiles as—

Mrs. BYRNE. You said, Dr. Morris, that they compare to one another, but they are also comparing to your criteria.

Dr. MORRIS. Right.

Mrs. BYRNE. It is how the others compare to your criteria? They are comparing, all right, to one another; but the umbrella under which they are compared is the criteria that you have set forward, correct?

Dr. MORRIS. Yes.

Mrs. BYRNE. OK. That is what I would like to see the committee get, to get an idea of what that umbrella looks like.

Dr. MORRIS. Well, let me try once again, because I maybe was not clear with you.

The criteria—let me list what some of the criteria are. The criteria relate to selection score, selection rank, one's Pro/File score, and Pro/File rank. The criteria include a number of factors that relate specifically to the patient access issue, so they deal with the volume of services that were provided in a given area during the

time prior to the evaluation, they deal with the numbers of patients and physicians in that special geographic area.

The criteria—those are the things that the criteria actually relate to one another, so it is merely setting up a relationship of one physician to another relative to the things I just listed.

Mrs. BYRNE. Right. Let me clarify what I am talking about.

It is my understanding from a number of the hospitals in the area that insurance providers are now saying that we need only about 24 hours in the hospital after a C-section. I am sure you are familiar with that.

Dr. MORRIS. Yes.

Mrs. BYRNE. OB/GYN's have told me that that is a tremendously stiff standard to meet, that sometimes we have to separate mother and child because the baby is kept in, and it is time to release the mother, and if they don't release the mothers, the insurance companies won't pay and it is a big hassle.

So if we have doctors willing to go along with 24 hours, a standard you have set, then they will be ranked higher than other OB/GYN's who don't go along with that standard, correct?

Dr. MORRIS. Incorrect.

Mrs. BYRNE. How is it incorrect?

Dr. MORRIS. First—let's see, where do we begin?

It is incorrect that that in itself will result in a physician being ranked higher. The whole concept of comparing, first, physicians to each other is they set the standards in the community; so the issue is, we don't compare physicians to say, did you or did you not reach x level of one-day stays? The standard is, what is the practice in the community? What are physicians across the metropolitan area and within—

Mrs. BYRNE. Dr. Morris, you have defined the standards by saying you will only pay for 24 hours' coverage. You have defined that standard already; that is your policy, correct?

Dr. MORRIS. No, ma'am.

Mrs. BYRNE. Well, I mean, if I want my patients to have insurance coverage and you guys tell me they are supposed to be out the door in 24 hours, that is a standard. If that standard is not being met by physicians, by the majority of physicians, it will affect them being measured against one another.

But if the majority of physicians accept that standard that you have set as to how much you are going to pay and when, then that affects the ranking that the majority accept—what you have said as what is customary practice for C-sections.

Dr. MORRIS. For our evaluation and selection purposes, it only matters—not what individual coverage policies have, as it really does depend wholly on how physicians in this community practice medicine.

Mrs. BYRNE. I think we are saying the same thing. You may not believe it, but I think we are. So if you could assure the committee that you will get us some kind of sketch of Pro/File to see what it actually has in it—

Dr. MORRIS. That I can do, yes.

Mrs. BYRNE. Thank you.

[The information referred to follows:]



**BlueCross BlueShield
of the National Capital Area**

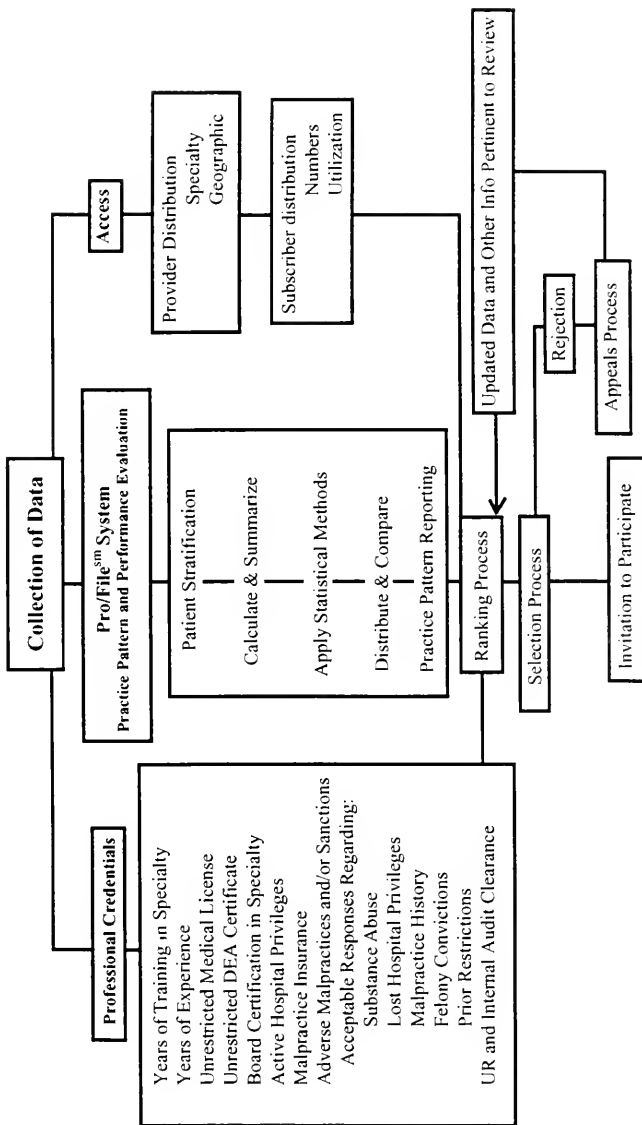
An independent licensee of
the Blue Cross and Blue Shield Association

How Providers Were Selected For the Select Preferred Provider Plan

Line 1864 -- Sketch of Pro/FileSM

The Select PPP was developed to provide quality care to patients while maintaining cost effectiveness. Physicians, hospitals and other health care providers are selected based on detailed information in their records. Consequently, BCBSNCA depends upon three primary requirements to determine the eligibility of providers for the Select PPP: professional credentials, practice pattern and performance evaluation and geographic distribution.

BCBSNCA uses multiple sources of data and multiple levels of evaluation in the selection process:



The Pro/FileSM System

Health care researchers have begun to document significant variations in patterns of provider practice that affect both the costs and consequences of patient care. Pro/FileSM is a state-of-the-art management information system that incorporates advanced analytical and sophisticated statistical techniques to assure measurement of patterns of provider practice and patient care at the highest levels of reliability and validity.

The data base is organized by patient, compiling from claim records the kinds, amounts, circumstances, and costs of services each patient receives from all providers over time during his/her episodes of care and intervals of coverage. Patients are grouped and analyzed separately (i.e., "stratified") based on quantifiable and distinguishing characteristics such as their health status, coverage, doctor relationship, age and sex, and type of condition and/or treatment.

Each provider's patients are compared only with other similarly-stratified patients in order to reflect the unique patient-mix of his/her practice. Hundreds of variables are considered from the thousands that are computed. There are no predetermined standards of performance; all evaluations are relative to the actual distributions of patient and provider experience within the community.

These measures can be used in conjunction with other information to support a wide range of management activities in the administration of health care benefit programs. They can also be transformed into graphic representations of each provider's practice patterns and those of his/her peers, a reporting of which can be shared with each provider.

Mrs. BYRNE. After you implemented SPPP, did you receive complaints from enrollees or their doctors that had been dropped from the network, and if so, how many?

Dr. MORRIS. Very few subscribers called to make any complaints whatsoever. Prior to or during the open enrollment period subscribers were given a directive that identified which physicians were or were not in the network so they made their choices based on knowledge of which physicians were in the network.

I have got few; in fact, I personally responded to only three or four subscribers who were not happy that the doctors were not in the network. But there was a very, very limited response from subscribers.

As I said, I think that one of the largest enrollments that we have had in a number of years actually occurred this year. So the Federal employees were voting with their feet, so to speak.

Mrs. BYRNE. Since you have implemented SPPP, have you realized any cost savings, and if so, how much?

Dr. MORRIS. I have not, to date, completed the analysis that tells us the cost savings.

Let me tell you what I do know. I do know our trends are down, our claims costs are down. In addition to those things, included with my testimony is, in fact, a document produced by Lewin-VHI that addresses the cost savings by networks, and that study suggests that the networks themselves bring anywhere from 11 to 23-percent savings.

Mrs. BYRNE. Okay, does that Lewin study, would that be applicable to your previous Preferred Provider package, too? If you took the PPP from 1990 and you juxtaposed it to the SPPP of 1993, what kind of figures do you think you would come up with, or have you done those calculations?

Dr. MORRIS. The analysis is not yet complete to answer that specific question.

Mrs. BYRNE. Do you expect it to be complete within the next few months? Could you put us on your mailing list?

Dr. MORRIS. Yes, it would be complete within the next few months.

Mrs. BYRNE. Thank you.

[The information referred to follows:]

The analysis mentioned has not yet been completed. We will share it with you when it is completed. In the meantime, we believe the differences in practice patterns and resultant costs in the examples cited in testimony are strong evidence of the savings we can expect.

Mrs. BYRNE. In your testimony, you state that Blue Cross/Blue Shield has an appeal process and that approximately 550 providers took advantage of that process.

Could you walk me through how this appeal process is implemented and what is the process?

Dr. MORRIS. OK. When a physician indicates that they want to pursue participation in the Select PPP after not having been invited, they are sent and are asked to complete a reconsideration form. That reconsideration form collects from them firsthand, specific information that would affect how they are ranked against other providers.

We then go back through with their responses and assure that those factors were correct during the evaluation process.

When those factors were correct, then there is an additional level of consideration. When the factors were not correct, then they are corrected and the reevaluation occurs and the determination is made whether they then, based on the selection process, were selected.

Now, I mentioned an additional level. There are a number of things that come into play here, and the issue that I raised about the practice unit is relevant. Let me address it here in the appeals process.

There are a number of people who say, I was not brought in, but I am in fact in practice with Dr. Jones. Well, we would go back and do a revaluation, and if we establish that there is reason to believe those two are practicing together, their information is merged, and in fact, if that results in the practice group being selected, the other physician is invited to participate in the network.

There are a number of permutations that occur. Physicians—new physicians in the area, for example, and in primary care. If the physician is new to the area, we don't have any negative information and they are willing to participate fully in our programs, they are allowed to participate in the Select PPP on an interim contract—on an interim basis until such time that we have the data to evaluate them.

There are a number of other permutations that can occur in the appeals process and, in fact, do occur.

Mrs. BYRNE. But they have to appeal—a new physician would, in effect, have to enter into the appeals process to get selected, would they not? You are just not going to take an application over the transom.

Dr. MORRIS. Well, if a new physician submits an application to participate, then, in fact, we would walk through the process with them and we would determine if there is, in fact, no negative information; and if they are willing to participate in the managed care networks, we will allow that person to participate on an interim basis.

Mrs. BYRNE. Is there an inherent disparity between group practice and sole operators? Since we are rating the practice and the checks are made out to the practice, of course, it is like spreading the risk. It is a risk pool, right?

Dr. MORRIS. No. This is not a risk pool at all.

Mrs. BYRNE. Well, if you have a sole practitioner, that sole practitioner is, and of himself, the practice.

Dr. MORRIS. Yes.

Mrs. BYRNE. If you have 20 people in a practice, those 20 people go up to make the practice.

Dr. MORRIS. That is correct.

Mrs. BYRNE. So that you have 20 factors in the practice. So we are spreading the risk in that practice.

Everything doesn't rely on the sole practitioner.

Dr. MORRIS. That is correct.

Mrs. BYRNE. What I am asking is, does Pro/File do any weighting to account for a practice that is 20 people or a sole practitioner?

Dr. MORRIS. Yes, several things.

Let me, in responding to that point—Pro/File software does, in fact, create some data and information for us and stratify it, but we actually make the decisions about how and when, or which physicians will or will not participate, so it is a management decision.

The computer doesn't decide who is in and who is not. What it does is it stratifies the data in such a way that a practice, one practice is comparable to another; and the fact that there may be 1 practitioner in one practice and 17 in another does not affect the ability to compare the practices. It is designed, in fact, to allow us to compare the one unit to another, independent of the number of operators within the unit.

One other reason for looking at it—and again, it is a management decision to look at the practice as an unit. The reason is that it is very common within practices and particularly in OB/GYN, for example, that physicians collectively treat patients; you may go in to see one doctor on one day and you might go to the doctor on another day and someone else may care for you. So we are concerned in looking at the collective impact on our subscribers. In some cases, it happens to be one individual providing all the care.

Mrs. BYRNE. Dr. Morris, I want to thank you for your patience with this committee.

As Chairwoman Norton said, this is a busy day today, and if you have no other further comments to make, I will call this hearing adjourned.

Dr. MORRIS. I would just like to thank you very much for the opportunity to present it to you today. Thank you.

Mrs. BYRNE. Thank you, Dr. Morris.

[Whereupon, at 1 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

JOINT PREPARED STATEMENT OF THE AMERICAN PSYCHOANALYTIC ASSOCIATION; THE WASHINGTON PSYCHIATRIC SOCIETY; THE AMERICAN ASSOCIATION OF PRIVATE PRACTICE PSYCHIATRISTS; AND THE ALLIANCE TO END DISCRIMINATION AGAINST MENTAL ILLNESS AND SUBSTANCE ABUSE TREATMENT (ADAMISAT)

Chairman Norton and Members of the Subcommittee: This testimony is submitted on behalf of several organizations of outpatient mental health providers, including The American Psychoanalytic Association, the Washington Psychiatric Society, the American Association of Private Practice Psychiatrists, and the Alliance to End Discrimination Against Mental Illness and Substance Abuse Treatment (ADAMISAT).

The members of these groups, consisting of several thousand medical professionals, believe it is crucial that psychotherapy patients and providers have complete freedom of access to clinically appropriate treatment in any comprehensive health care system, whether Blue Cross/Blue Shield of the National Capital Area (BCBSNCA) or a national health care system. Ample evidence demonstrates that psychotherapy, when based on clinical judgment, is not only highly effective in treating the individual patient, but is also cost-effective for society as a whole in preventing other medical costs, disability and lost productivity. (See the fact sheet attached as Exhibit A.) We are concerned, however, that the benefits of mental health coverage may be limited or lost by bureaucratically-imposed, arbitrary treatment limits. The most insidious threat is that of aggressive managed care/utilization review procedures which effectively prevent patients from obtaining necessary treatment even though such treatment may theoretically be included in their benefits package.

Restrictions on Provider Panels

One of the financially driven methods by which the availability of adequate and appropriate treatment is restricted is the use of closed provider panels "stacked" with practitioners selected on the basis of brevity of treatment and amenability to managed care procedures, and with few, if any, highly qualified, experienced practi-

tioners. The actions of BCBSNCA being considered by this subcommittee are clear examples of this.

Firms which employ managed care tactics have in general become increasingly aggressive in a way that is unabashedly hostile to any kind of in-depth, intensive psychotherapy. They have done this by excluding from provider panels psychoanalysts and other psychodynamically-oriented mental health professionals who have the additional training and skills to do intensive psychotherapy.

These entities promulgate a view of psychotherapy which they term "progressive" but is in fact regressive and restricted to superficial, directive approaches. They conduct re-education efforts that elevate such short term treatment to a shibboleth and, ironically, describe as "regressive" any technique that would foster the development of a committed, trusting doctor-patient relationship. They actively and explicitly discourage treatment in which the patient can feel safe in opening up, exploring, and discovering the real causes of distressing and disabling symptoms so that fundamental changes can be made and endless dependence on drugs for symptom relief can be avoided. Practitioners who undertake such treatment find themselves pressured and excluded from the plan.

Another consequence of such tactics is that patients are often forced to switch therapists, for example, when the patient's therapist cannot get onto the panel, or is on the panel but is then "deselected" as BCBSNCA is now doing. To require a patient in intensive psychotherapy to change their psychotherapist or analyst is akin to requiring surgeons to attend a fire drill in the midst of a complicated surgical procedure. The relationship with the treating therapist is central; its preservation throughout the treatment with maintenance of absolutely privacy, stability, and confidentiality are critical. (We note that the American Psychiatric Association's principles state clear support for a continuity of care by the same provider for an ongoing treatment, whether the provider is a panel member or not.)

The harm to patients and quality of care by use of restricted panels of physicians by managed care companies is considerable. Specifically, the impact on psychotherapy, a critical service in the treatment of the mentally ill, and the least restrictive and least expensive setting, is extremely destructive. As highly experienced professionals, we rarely, if ever, see any rational basis for selection of panel members, let alone any clinically or quality of care based reason for the panels. By far the most important basis for selection and "de-selection" of practitioners appears to be financial. As Sen. Paul Wellstone accurately put it, "When health plans exclude a physician, the politically correct phrase is 'de-selection.' Don't be fooled: 'De-selection' is code for 'economic cleansing.' Insurance companies are out to protect their bottom line, no matter what it does to patient care. Legislative protections are necessary to prohibit your health plan from kicking out doctors for the crime of simply giving you the care they think you need."

Moreover, even judged simply on financial terms, such panels give only an illusion of cost control. The lack of care, lack of proper expertise, training and specialists, and disruption of care ultimately cost society, if not the plan, more in medical expenses, disability, police and criminal justice and other expenses. (See fact sheet, Exhibit A.)

Protection of the Environment for Effective Treatment

Most psychoanalysts and psychodynamic therapists have now seen patients who come at their own expense to avoid the unnecessary managed care environment, and many have had highly distressing experiences of almost ludicrous interference with appropriate, effective evaluation and treatment. The environment for effective treatment—the fundamentals without which no treatment can take place—are confidentiality and privacy, the security and continuity of the analyst-patient relationship in an environment free from harassment, and the patient's full participation in all decisions about his or her treatment. Decisions must be based on clinically appropriate criteria that are known to all interested parties, any review conducted by true peers who are experienced in the treatment method being reviewed, with no direct or indirect financial incentive to withhold treatment.

Of fundamental concern regarding mental health is undue reliance on the concept of "managed competition" as being the preferred mechanism for the delivery of services within organized systems of care. To be sure, there are examples of mental health services delivered within organized systems which are fair and effective. Kaiser-Permanente had an open outpatient benefit prior to the enactment of federal HMO restrictions and the classical studies demonstrated its efficacy and cost-effectiveness. However, patients and clinicians alike can document the fact that in recent years many HMO's have provided services for mental illness which are far inferior to those provided for other illnesses as well as inferior to services provided in a tra-

ditional indemnity insurance setting. A recent RAND study confirms this contention. Investigators found that HMO patients suffering from depression not only did not improve compared to indemnity insured patients, they got worse. This is not surprising where the necessary conditions for treatment are disrupted.

CONCLUSION

We ask that you look closely at the fundamentals without which no treatment can take place, and work with us to achieve explicit protections to ensure that each of these fundamentals is protected. We must prevent manipulation of provider panels and related barriers to treatment in order to control costs at the expense of necessary and appropriate care. (Specific proposals are contained in Exhibit B.) In addition, if managed competition is to be the basis of health care delivery, there must be a genuine fee-for-service alternative without financial penalties that allows patients, regardless of means, to choose their own physicians or therapists and to protect the privacy and integrity of their treatment without the threat of profit-driven obstruction and distortion.

It will not matter how many visits or days in the hospital are covered or what the co-payment will be if patients with mental illness and drug disorders are systematically denied access or are exposed to care of an inferior quality. It is essential that patients be provided adequate treatment, which requires the availability of highly skilled, well-trained, experienced practitioners and the development of a secure, trusting, stable and uninterrupted patient-therapist relationship.

You will hear great protests from administrators and entrepreneurs that limited, closed panels are necessary. For the sake of the mentally ill and of American society as a whole, please listen carefully to the actual clinical needs of good treatment and do not be deceived by those who place their own profit above that care.

Exhibit A

Fact Sheet: The Case for Effective Psychotherapy Coverage

Psychotherapy is an essential part of the American health care system, overwhelmingly supported by the American public. 98% of Americans believe health insurance should cover mental illness treatment; 87% say a visit to a psychiatrist should receive the same coverage as any other medical treatment.¹ Although it amounts to a small fraction of the system's costs, access to psychotherapy is vital to individual health and highly cost-effective for society.² However, in order for psychotherapy to effectively address highly sensitive personal issues, a patient-therapist environment of confidentiality, continuity, security, and trust must be carefully preserved. When these conditions are disrupted by cumbersome, intrusive bureaucratic requirements, arbitrary coverage limits, and lack of patient choice, psychotherapy exists in name only. This fact sheet explains the need for truly effective, comprehensive access to psychotherapy as part national health care reform.

UNTREATED MENTAL ILLNESS AND SUBSTANCE ABUSE COST BILLIONS

Mental illness was estimated to cause \$74.9 billion in lost productivity in 1990.³ The total annual costs of mental illness and substance abuse (other than direct treatment) are estimated at over \$225 billion.⁴ Six of the top ten causes of death are associated with mental illness and substance abuse.⁵ A recent M.I.T. study estimates an annual cost of \$11.7 billion in lost work days and \$12.1 billion in other lost productivity from depression-related mental illness alone.⁶ Depression causes more social disability (interference with work, family and other functioning) than the eight most common physical illnesses.⁷ An estimated \$33 million is spent annually on unnecessary angiograms caused by panic disorder.⁸

PSYCHOTHERAPY WORKS

Psychotherapy has been better studied than many other medical treatments and the data have been consistently positive. Improvement rates for psychotherapy range from 65%–92%, with the higher figures reflecting the most clinically appropriate type and duration of treatment.⁹ In one study, for example, psychotherapy doubled the life expectancy (3 years vs. 18 months) of patients with metastatic breast cancer.¹⁰

¹Footnotes at end of article.

THE COST OF PSYCHOTHERAPY IS STABLE AND RELATIVELY SMALL

Psychotherapy is only used by about 4.3% of the population, even when fully covered.¹¹ Only 0.4% (1/250) have over 40 visits. Mental health costs have been stable at approximately 10% or less of health care expenditures; psychotherapy costs about 1.6% of the health care dollar.

PSYCHOTHERAPY IS HIGHLY COST-EFFECTIVE

The economic benefits include reduced expenses for inpatient mental illness and other medical treatment (both in- and outpatient), improved work attendance and productivity, improved family functioning, less antisocial behavior and decreased crime-related costs.¹² The net economic benefit of full coverage for treatment of the most severe mental illness alone has been estimated at over \$2 billion per year. The most extensive analysis of medical cost offset data found that outpatient psychotherapy lowers the rate of hospitalization on average by 73.4%, and substantially reduces time spent in the hospital.¹³

Mental illness treatment is often necessary to effectively treat physical illness. For example, intensive psychotherapy to lower distress and disability levels and make necessary life changes is more effective and vastly cheaper than a coronary artery bypass (avg. \$40,000+) for angina patients.¹⁴

THE ENVIRONMENT FOR EFFECTIVE THERAPY MUST BE PROTECTED

Psychotherapy, like other medical treatment, requires a special environment. In surgery, for example, sterility in the operating field is essential. For psychotherapy, the conditions are different but no less important. These include the patient's freedom to choose a therapist with whom trust can be established, to select an appropriate mode of treatment and have a voice in treatment decisions.¹⁵ Privacy, security and continuity in the ongoing patient-therapist relationship are essential.

REASONABLE INTENSITY AND LENGTH OF TREATMENT ARE NECESSARY

Treatment beyond arbitrary limits, such as 30 visits, is sometimes necessary, particularly for individuals with conditions such as chronic childhood trauma, adolescent eating disorders, sexual abuse, borderline personality disorder, and major depression.¹⁶ Although these are a small minority of the population, they represent an extremely cost-effective use of psychotherapy provided intensity and duration are determined by medical criteria only.¹⁷ Otherwise, this group is likely to cost society far more in medical treatment, disability, family support, and criminal justice expenditures.

ABUSIVE MANAGED CARE BUREAUCRACIES UNDERMINE TREATMENT

In the last decade, financially-driven "gatekeeper," managed care, and utilization review procedures have increasingly dominated American health care, including mental health treatment. The perceived need for short-term profits has often resulted in the dramatic abuse and distortion of the practice of psychotherapy.

As in other areas of health care, patients or providers are often required initially to seek treatment approval from an anonymous administrator, or a non-specialist "gatekeeper" who is highly motivated to minimize the need for referrals. This usually requires the patient to disclose highly personal, private matters to a stranger over the telephone. Assuming that the patient is allowed treatment, there is often little or no freedom to select the most appropriate practitioner or mode of therapy. Provider panels often lack highly qualified, experienced psychologists or psychiatrists. Moreover, provider panels commonly consist only of "cooperative" practitioners selected for brevity of treatment. As one practitioner accurately put it, being labelled an advocate of long-term treatment "is akin to being identified as a Communist."¹⁸

Assuming further that a patient has the freedom to select a compatible psychotherapist and begin treatment, still more hurdles exist in the form of case management and utilization review procedures. These typically include cumbersome, time consuming and often duplicative demands for information and blatant invasions of the patient-therapist relationship, such as requirements for detailed personal information obtained by the therapist in strict confidence. Utilization reviewers often have minimal or no mental health qualifications and simply rely on generalized guidelines or averages to terminate treatment as quickly as possible. Difficulty and delay in obtaining coverage decisions, arbitrary treatment limits, use of statistical averages in the guise of medical judgment, and the manipulation of provider panels have the net effect of "blackmailing" therapists to provide only fast, cheap treatment.¹⁹

RESTRICTIONS ON OUTPATIENT TREATMENT INCREASE MORE COSTLY INPATIENT TREATMENT

Effectively withholding treatment until people hit bottom is the most expensive and least effective (not to mention least compassionate) approach.²⁰ For every extra \$1 spent on expanding outpatient psychotherapy, \$4 are saved in inpatient costs. Australia provides a full continuum of mental illness treatment ranging from hospitals to long term, intensive psychotherapy. New Zealand generally limits mental health treatment to hospital only for the "seriously mentally ill," yet New Zealand's mental health system costs 35% more per capita than that of Australia.²¹

LIMITS ON COVERAGE DISPROPORTIONATELY AFFECT THE ALREADY DISADVANTAGED

Among those for whom psychotherapy is most often indicated are victims of violence, trauma and abuse, those with anxiety and eating disorders, pregnant and nursing women with depression, and those with serious physical illness.²² Many of these, particularly the poor and sick, are also most affected by coverage limits and co-payment requirements, and are more likely to be minorities, women and children. Failure to promptly and adequately treat tends to cause functional disability, thus worsening the condition. Children in particular are the most vulnerable, yet they (and society) stand to benefit the most from their treatment.

What is needed: Full, non-discriminatory coverage for a continuum of mental illness treatment, including psychotherapy, is a necessary part of a national health care system. However, such a system must ensure that the conditions for effective psychotherapy are not compromised. These can be accomplished through a patients' bill of rights, of which all patients should be informed, consisting of the following:

1. *Freedom of contract and freedom of choice*

Protection of the right to seek a qualified provider of one's choice is vital to the survival of psychotherapeutic treatment.

The most basic protection is the right of patients and providers to contract privately completely outside the health care system, without penalty or prejudice to the right to otherwise participate in the system. When benefits cover only part of treatment costs, patients should be free to contract privately for the remainder either out of pocket or through supplemental insurance.

Provider panels should be open to any qualified professional and a point of service option should be available to permit a patient to select an outside provider without undue financial penalty.

2. *Protection from managed care abuses*

The environment for effective treatment, including privacy, security, and continuity must be preserved. Utilization decisions must be made in a timely and non-invasive manner by financially disinterested professional peers, based solely on published clinical criteria.

3. *Full, parity coverage of a continuum of mental illness treatment*

All Americans should have coverage sufficient for the full range of mental illness treatment, including psychotherapy, under the same conditions as all other medical coverage. We seek the widest possible access to genuinely effective long-term and/or intensive psychotherapy to the extent it is clinically indicated; no more and no less. This coverage is a necessary part of true health security for all Americans.

REFERENCES

¹98% of the American public say insurance should cover mental illness treatment; 87% say a visit to a psychiatrist should receive the same coverage as any other medical treatment. Mark Clements Research, Inc., Census-weighted survey, Parade October 31, 1993.

²Supporting documentation for the data presented regarding the efficacy, cost and cost-effectiveness of treatment include studies of the Federal Employee Health Benefit Program, the CHAMPUS military health care system, and numerous other studies (58 are discussed in Mumford, et al., *Am. J. Psychiatry* 141:1145-1158), including Stoudemire et al., *Gen Hosp. Psychiatry* 8:387-394; Linehan et al., *Arch. Gen. Psychiatry* 48:1060-1064, 50:971-974; Graves et al., "Psychological Intervention and Medical Utilization in Children and Adolescents of Low-Income Families," *Prof. Psychology* 12:426-433; Horwath et al., *Arch. Gen. Psychiatry* 49:817-823 (1992); Langsley et al., *Am. J. Psychiatry* 127:1391-1394; Schlesinger et al., *Am. J. Public Health* 73(4):422-429; Mintz, *Arch. Gen. Psychiatry* (1992) 49:761-768; Broadhead, *JAMA* 10/90; "Research on Children and Adolescents with Mental, Behavioral and Developmental Disorders," (*Natl. Acad. Press*) 1989.

³Stoudemire et al., *Gen. Hosp. Psychiatry* 8:387-394; Andrews, "Private and public psychiatry: a comparison," *Am. J. Psychiatry* 146:881-886.

⁴ADAMHA, *Estimated Cost of Alcohol and Mental Illness*, 1985.

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⁶ Greenberg et al., *J. Clin. Psychiatry*, Nov. 1993.

⁷ Wells et al., "Cost-Sharing and the Demand for Ambulatory Mental Health Services" *Rand Corp.* 1982.

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Exhibit B

Legislative Recommendations re: Provider Panels

1. ALL WILLING PROVIDERS

A practitioner shall not be denied the right to become a panel member or participating provider, or the right to payment for services which s/he is licensed, certified otherwise authorized by law to provide, if:

(1) The practitioner can satisfy the reasonable professional qualifications and quality of care standards of the plan.

(a) Such qualifications may include the standards of education and/or training established by nationally recognized professional associations specifically designated for this purpose.

(b) Any standards shall take into account case mix, severity of illness, patient age, and other factors that may account for a practitioner's practice characteristics.

- (2) The practitioner agrees to accept the same compensation schedule applicable to other practitioners of the same profession for the same health care service; and
- (3) The practitioner complies with the terms of the plan's applicable standard provider contract, provided however, that said contract may not require any terms or conditions which negate or alter the foregoing provisions, nor any terms or conditions which prevent or discourage the making of treatment decisions based solely on clinical necessity and appropriateness.

2. PATIENT PROTECTION ACT

The following provisions based on the Patient Protection Act introduced by Sen. Wellstone provide at least minimal protections from manipulation of provider panels.

A. Full disclosure of panel information

1. Consumers must receive easily understood information regarding (a) which services are covered and excluded, (b) authorization and review procedures, (c) any financial arrangements that would limit, or establish incentives to restrict, the services offered or referral options, (d) the percentage of premium dollars spent on direct patient care, (e) plan limitations and their impact on the enrollee, (f) complete details of the professional qualifications, experience and expertise, and the criteria for selection, of panel members and (g) statistics on patient satisfaction. This information shall include a written description of any exclusions in the types of participating providers, such as particular specialists. (However, plans must have providers in sufficient numbers and with ample experience, training and expertise for all mental health services.)

2. No incentives, direct or indirect, financial or otherwise, for reduction of services through utilization review shall be permitted. Any incentives to practitioners must be based on use of proper clinical judgment as to medical necessity and appropriateness, and must be fully disclosed to all providers and plan participants.

B. Fairness and provider due process

1. Plans must provide public notice when taking applications for participation by providers;

2. Standards for contracting with providers, including credentials, must be spelled out in detail to practitioners and patients;

3. A plan must notify a practitioner of a decision to terminate or non-renew 45 days in advance. The notice must contain reasons for termination or non-renewal consistent with announced standards including those set forth above;

4. A decision to terminate must be reviewable by a group of the practitioner's peer.

PREPARED STATEMENT OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

The Medical Society of the District of Columbia (MSDC) is filing this statement for the record to clarify data that was submitted at the hearing and to provide responses to several issues raised at the hearing.

MSDC realizes that the subcommittee hearing was in many ways a microcosm of the issues members are grappling with as they deal with health reform—issues of cost containment, choice, access, quality, information for consumers and provider selection. Once again, we appreciated your efforts to examine these subjects as they relate Blue Cross/Blue Shield of the National Capital Area and the Federal Employees Health Benefits Program (FEHBP).

First, MSDC would like to modify the information supplied to the subcommittee on the deselection of OB-GYNs in the Select Preferred Provider Plan (SPPP). An error in exact numbers was due to a data input problem. The corrected numbers, which have been hand verified, while somewhat different, show the same patterns MSDC presented to the subcommittee. There has been a substantial deselection of OB-GYNs in the Northeast and Southeast areas of the District. These are neighborhoods where lack of pre-natal care, low birth weight and infant mortality are serious problems. Yet at the same time, there was not a similar deselection pattern in Northwest. Here's what the data shows: In Northeast and Southeast, the number of OB-GYNs deselected represented a 59% reduction, from 32 down to 13. At the same time, the OB-GYNs in NW were reduced only 11%, from 128 to 114.

MSDC must tell you that the data we have is based on the directories printed by BCBSNCA. So, if there are shortcomings in the data, it is because BCBSNCA may have made more changes in their network without publishing the information. We believe this is also a flaw in the system for consumers not to have the most up to

date information. This is true for current enrollees and potential members. Despite this shortcoming, we believe that you correctly captured what we were trying to demonstrate at the hearing—that deselection is not only a matter of numbers, it has to do with access. Access and geographic location are linked. And when you are talking about the location of certain types of providers, particularly in an area like the District, the location of available providers can have profound implications for the community.

BCBSNCA was asked during the hearing whether or not all the providers in a community could be “selected out” and was told by Dr. Greg Morris “not by design.” This is hardly an acceptable answer and the impact of the deselection process felt by area doctors and their patients demonstrates what happens when a selection/deselection process goes awry. When further pressed about whether BCBSNCA had looked at the impact on the community of the deselection decisions for SPPP, Dr. Morris suggested this was implicit in the system. An analysis of the data shows otherwise.

When we examined the location of the OB-GYNs, we found a substantial reduction in the OB-GYNs in NE, SE and SW and a much smaller reduction in NW. Specifically, NE OB-GYNs were reduced 53%; in SE, they were reduced by 63% and in SW, there was a reduction of OB-GYNs by 50%. By contrast, there was only a 14% reduction in the number of OB-GYNs in NW. In fact according to the data we have from BCBSNCA, there are 113 OB-GYNs available under SPPP, unfortunately, NE has only 8, SE has only 6, and SW has 2. It's hard not to believe there is a relationship between the nature of the patients and the providers who have been deselected when you see these kinds of numbers. A chart listing the deselection differences by zipcode is attached. Slight differences in the total number relates to using quadrants versus zipcodes and the reduction in duplicate offices for each.

The answers received by the subcommittee over what implication the Pro/file system could have, also points up another flaw with the selection process used by BCBSNCA. Rather than collecting profiling data on physicians, sharing that information with them, explaining it and then showing how performance could be changed, BCBSNCA elected to deselect doctors first. As MSDC explained at the hearing, we support properly used physician profiling, we support an emphasis on quality, and we support giving consumers more information on which to make informed choices about their health plans and individual providers. However, this must be done in a manner in which the focus is educational, not punitive. There must be verification of the profiling selection methodology by chart review and outcomes measurement, even if done on a limited basis. It must be a process that seeks continuous quality improvement; we do not see that as a part of how BCBSNCA currently selects its providers.

If changes in the market towards managed care are to be successful, then a stronger partnership between doctors and the managed care organization must be formed, this benefits the members of the health plan. But it won't happen if practicing doctors don't have input into this process, and still have yet to see a full explanation of the selection process or a formal appeals process on paper. The Pro/file system is such a “black box” that, for example, although MSDC is told that the Pro/file system makes adjustments for the health status of the patients of the doctors profiled, we have no written documentation to verify this and, in fact, the initial number in OB-GYN demonstrate otherwise.

Despite the description of Pro/file provided by Dr. Morris at the hearing, MSDC still remains in the dark, about just how the process works, not to mention exactly who it was and wasn't applied to. We hope the subcommittee will be able to obtain such a description. For example, a very important question was asked but never answered during the hearing relating to the community standards of practice, the basis on which the profiling is done. What about those many areas in medicine where this is disagreement over such specifics? The example raised at the hearing related to how long a woman should remain hospitalized following the birth or her child. The question, never properly answered, shows another potential flaw in the system.

MSDC learned when SPPP was established, that Pro/file was not applied equally to all physicians who were selected to participate. BCBSNCA admits that the physicians affiliated with teaching hospitals were automatically waived in. The same is true for some group practices. At the hearing BCBSNCA also said they did not apply Pro/file to certain specialists, but they did not elaborate. At a minimum, MSDC believes their advertising for the SPPP product should not imply that the same selection process, using Pro/file was applied to all the doctors in the network, because this is not the case.

Finally, with regard to the Office of Personnel Management (OPM) MSDC is in the process of arranging a meeting as requested by Del. Eleanor Holmes Norton.

While OPM was very supportive of BCBSNCA at the Compensation and Employee Benefits Subcommittee and complimentary of how much money they were saving, they spent no time in their written testimony and scant time in their answers, discussing the OPM oversight process for carriers. In fact, OPM stated that "if we don't get a lot of phone calls, we don't investigate." However, for anyone who followed the hearings on BCBS held by the Permanent Subcommittee on Oversight and Investigations, chaired by Senator San Nunn (D-Ga) as part of his continuing investigation of BCBS, OPM presented a different type of statement. Specifically, OPM, in its written and oral remarks was defensive about its ability to do appropriate oversight given the size of the FEHBP and OPM staffing levels. OPM indicated that it hopes to shift more staff to this function sometime soon. MSCD respectfully suggests that a system for better FEHBP enrollee monitoring be established and staffed.

Once again the Medical Society of the District of Columbia thanks the subcommittee members for its time and attention to these very important issues.



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	SPP/BOARD*	SPP/NON**	SPP/TOTAL	SPP/PPND***	PERCENT DECREASE	PPN/BOARD	PPN/NON	PPN/TOTAL	SPPB/PPNB****
20001 NW	3	2	5	0	0%	3	2	5	0
20002 NE	1	2	3	1	25%	2	2	4	1
20003 SE	2	0	2	1	33%	2	1	3	0
20006 NW	5	1	6	1	14%	5	2	7	0
20007 NW	21	5	26	-4	-18%	16	6	22	-5
20008 NW	2	0	2	-2	-200%	0	0	0	-2
20009 NW	1	3	4	1	20%	3	2	5	2
20010 NW	3	4	7	5	42%	10	2	12	7
20011 NW	1	0	1	5	83%	5	1	6	4
20012 NW	1	0	1	1	50%	1	1	2	0
20016 NW	6	1	7	2	22%	9	0	9	3
20017 NE	4	0	4	8	67%	12	0	12	8
20019 NE (NE/SE)	1	0	1	0	0%	1	1	1	0
20020 SE	2	0	2	3	60%	3	2	5	1
20024 SW	2	0	2	2	50%	4	0	4	2
20032 SE	1	1	2	6	75%	5	3	8	4
20036 NW	7	2	9	1	10%	8	2	10	1
20037 NW	31	9	40	3	7%	35	8	43	4
20059 NW	4	0	4	4	50%	6	2	8	2
20060 NW	0	1	1	1	50%	1	1	2	1
NW	85	28	113	18	14%	102	29	131	17
NE	6	2	8	9	53%	15	2	17	9
SE	5	1	6	10	63%	10	6	16	5
SW	2	0	2	2	50%	4	0	4	2
TOTAL	98	31	129	39	23%	131	37	168	33

*SPPP stands for the 1994 BlueCross BlueShield Select Preferred Provider Plan.

Board stands for board certified.

**Non stands for non-board certified.

***PPN stands for the BlueCross BlueShield Preferred Providers Network as of March 1992.

D stands for the difference between the two plans.

****SPPB/PPNB stands for the difference between the number of board certified doctors for each plan.

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